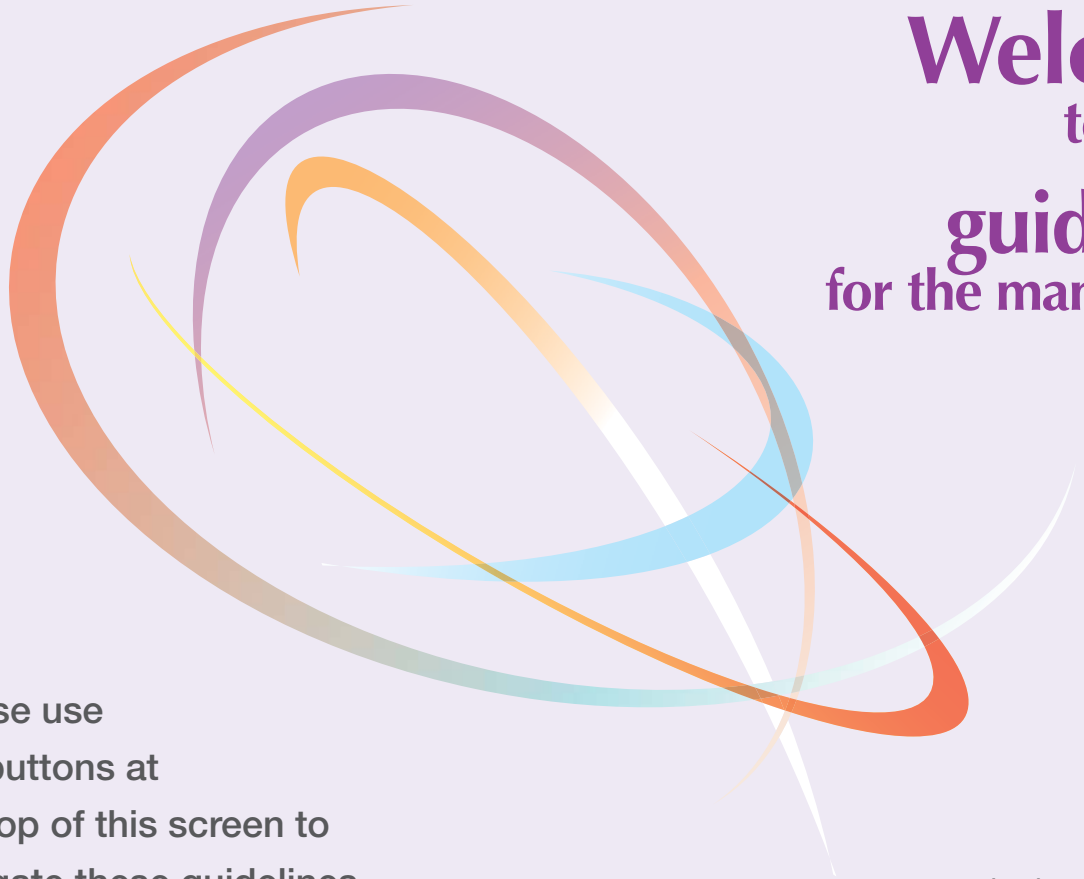

Welcome to the MIPCA guidelines for the management of migraine

please use
the buttons at
the top of this screen to
navigate these guidelines

this electronic version of the
'MIPCA guidelines for the management of migraine'
has been sponsored by an educational grant from GlaxoSmithKline

MIPCA MIGRAINE IN PRIMARY CARE ADVISORS

MIPCA is an independent charity 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.

MIPCA is the premier UK organisation dedicated to the improvement of headache management in primary care. MIPCA works with academic societies, governmental groups, healthcare professionals and patient organisations that deal with headache. It has separate sections covering education, research and the practicalities of setting up of headache clinics. Over the past decade, it has produced a significant body of work (books, academic publications, newsletters and slide sets) that are available to its members. MIPCA also has a dedicated website in development. If you are interested in joining MIPCA, please go to the 'Contact' page in this section, which contains an application form for membership.

Acknowledgements

The guidelines would not have been possible without the input and endorsement from the physicians, nurses, physical therapist and representatives of patient groups who attended the MIPCA Guidelines meetings on 24 May and 9 August 2002. We wish to thank all the delegates at the meetings: Chairman; Dr Andrew Dowson; GPs; Dr Bill Laughey, Dr Anthony Bland, Dr Douglas Bremner, Dr Frances Carter, Dr Stan Darling, Dr Heather Fearon, Dr Sue Lipscombe, Dr Trevor Rees, Dr Jerry Sender, Dr David Watson; Chiropractor; Dr Gregory Parkin-Smith; Nurses; Ms Jan Dungay, Ms Heather McBean; Patients' group (Migraine Action Association); Ms Ann Turner, Ms Anita Few. We also thank the numerous physicians who reviewed the guidelines and provided valuable input.

MIPCA is pleased to acknowledge the assistance of Allergan, GlaxoSmithKline, The Migraine Action Association and York Nutritional Laboratories, who sponsored the two meetings with unrestricted educational grants. GlaxoSmithKline sponsored the production of the CD-ROM and online versions of the guidelines. Dr Pete Blakeborough of Alpha-Plus Medical Communications Ltd provided consultancy and assistance with the drafting of the guidelines. Paul Burt designed the electronic document.

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Rationale

Welcome to this electronic document, which summarises the new Migraine in Primary Care Advisors (MIPCA) guidelines for the management of migraine in primary care in a dynamic and interactive form. MIPCA has devised rational, evidence-based guidelines for the management of migraine that are categorised into several clinically appropriate areas:

- Initial assessment of the patient
- Diagnosis of migraine and other headache subtypes
- Assessment of illness severity
- Initial treatment of the patient
- Follow-up treatment
- Practical aspects of managing migraine in the clinic.

MIPCA has also put together '10 Commandments' of headache management, which summarise the guidelines in a brief, simple to use format.

This document details all these aspects in seven sections, each subdivided into separate fields containing specific topics. There are links to the relevant fields in other sections, so that the professional can rapidly access all the areas for the specific topic they need to understand. Browsing through the whole document provides a full picture of the MIPCA guidelines for personal or educational use. In addition, useful questionnaires and forms are included, which can be printed for use in the clinic. Finally, each section includes cross references to the '10 Commandments', further reading and links to websites that can be accessed for additional information.

Overview

Following a year-long consultation process, MIPCA has recently launched new guidelines for the management of migraine in primary care. This document provides simple to use, rational, evidence-based guidelines designed for everyday use by primary healthcare professionals. New algorithms are included for the diagnosis and management of migraine, and a list of '10 Commandments of Headache' provides the dos and don'ts of migraine management at a glance.

The principles of the new MIPCA guidelines are:

- To conduct specific consultations for headache.
- To instigate a system of detailed history taking, patient education and engagement with care at the outset of the consultation.
- To utilise a new screening algorithm for the differential diagnosis of headache, which can be confirmed, if necessary, by further questioning.
- To institute a process of management that is individualised for each patient, using a new algorithm. Assessing the impact of headache on the patient's daily life is a key aspect of diagnosis and management.
- To prescribe only treatments with objective evidence of good efficacy and tolerability.
- To utilise prospective follow-up procedures to monitor the success of treatment.
- To organise a team approach to headache management in primary care (Figure 1).

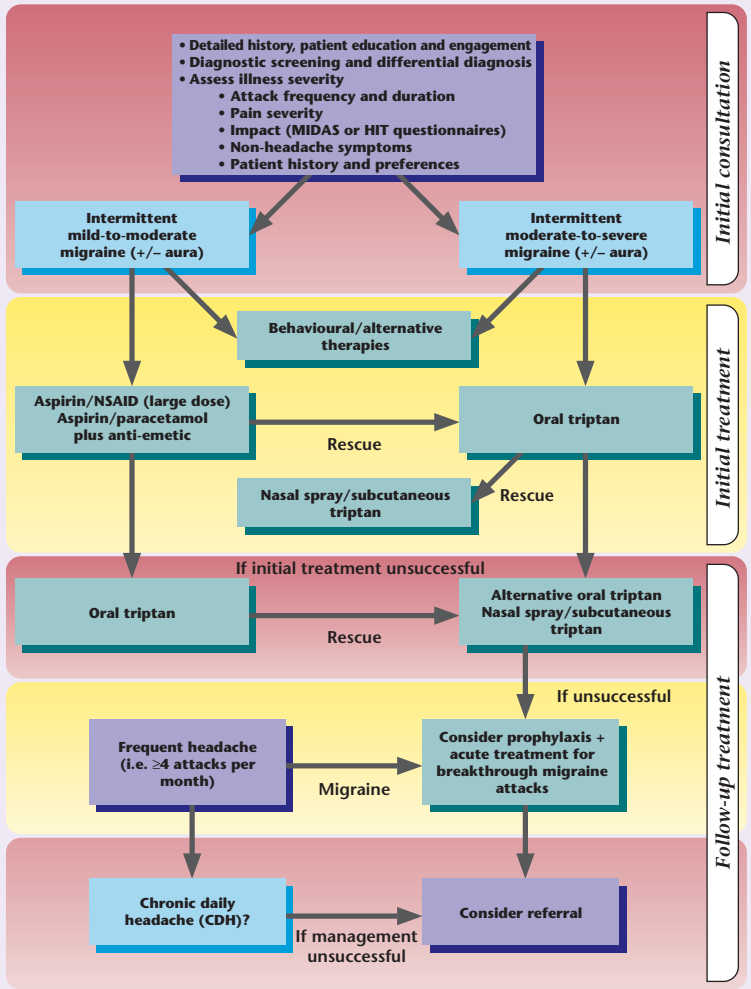


Figure 1. The new MIPCA algorithm for the management of migraine in primary care (click here to open a larger version)

Audience

This document is aimed at all healthcare professionals who deal with people who have headache:

- GPs
- Specialist physicians with an interest in headache, including neurologists and headache specialists
- Practice nurses
- Nurse practitioners
- Pharmacists
- Physical therapists
- Complementary practitioners.

It is also aimed at patient support organisations, who provide invaluable information and support to headache sufferers.

Contact

If you are interested in joining MIPCA please print out and complete the questionnaire/form which can be accessed here.

Please return the questionnaire/form to the secretariat at:

MIPCA, c/o Surrey Headache Service, Merrow Park Surgery, Kingfisher Drive, Merrow, Guildford GU4 7EP
Telephone/fax 01483 450755

Links

References:

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.

Websites:

MIPCA: www.mipca.org.uk

Initial assessment of the patient

Detailed history, patient education and engagement

Taking a careful history and a physical examination are essential key tasks of the first consultation for migraine. The use of a headache history questionnaire is recommended. A headache diary can also be given at this visit

The practice nurse can often, if available, conduct the history assessments, while the physician conducts the physical examination.

No single symptom defines migraine and the physician can use the history to create a clinical profile representative of the headache pattern. The history should cover:

- Headache: the impact, type, severity, location, duration, frequency, timing and family history
- Other symptoms: visual, sensory, gastrointestinal and neurological (e.g. slurred speech and loss of coordination)
- Influencing factors: genetic, diet, lifestyle, hormonal and environmental
- Current and past medications taken for headaches and other conditions including OTC medications.

Patients should be provided with good education about their migraine in the form of advice, leaflets and website information. People with headache are often motivated to understand their condition and physicians should provide them with information on the nature and mechanisms of their disorder. The UK patients association, The Migraine Action Association (MAA), is an invaluable source of information and advice for patients (helpline: 01536 461333). The MAA has a particularly useful booklet on migraine that is specifically designed for patient use. There are also excellent short books on migraine and other headaches that can be recommended to the patient (see 'References'). The practice nurse can often help with this advice.

Patients should be encouraged to take charge of their own migraine management and engage with the course of treatment. Patient engagement to the course of treatment can be optimised by effective communication between the patient and their physician. Patients should be told that migraine cannot be cured, but can be effectively controlled. Patients should also be encouraged to manage their condition themselves, making decisions about lifestyle alterations and how and when to take their medications. Physicians should encourage their patients to participate in their own management and effective communication between the physician and patient has been shown to improve care delivery. Patient preference is an important consideration in the choice of treatment. Patients may rate such factors as speed of response, overall headache relief, a lack of side effects or convenience as the most important characteristics of treatment. Conducting a careful physical examination can aid this engagement process, as it reinforces to the patient that the physician takes their condition seriously.

Headache history questionnaire

Please ring the relevant term or terms that best describe your headache

Severity

Mild Moderate Severe

How would you describe the pain?

An aching pain
A throbbing pain
A stabbing pain
A burning pain
None of these

Frequency

Several times a year
Several times a month
Several times a week
Once a year
Once a month
Once a week

Do you have any other symptoms during the headache?

Nausea/vomiting
Visual disturbance
Feelings of weakness
Speech difficulties
Loss of appetite
Dizziness
Sensitivity to light/noise
Numbness/tingling

Advance warning

Always Sometimes Never

Is the headache so bad that you have to go to bed?

Always Sometimes Never

What sort of warning do you get?

Visual disturbance
Numbness/tingling
Speech difficulties
Sensitivity to light
Feelings of weakness
None of these

How long does your headache last?

Less than 1 hour
1 to 4 hours
4 to 6 hours
6 to 12 hours
12 to 24 hours
More than 24 hours

Where is the pain usually located?

Top of the head
Back of the head
One side of the head
Both sides of the head
Front of the head
Other

Links

'10 Commandments'

See Commandment 3

References:

Dowson AJ, Cady RK. *Rapid Reference to Migraine*. Mosby: London, 2002.

Dowson AJ. Your Questions Answered: Migraine and Other Headaches. Churchill Livingstone: Edinburgh, 2003.

Lipton RB, Stewart WF. *Managing your migraine. A guide for people with migraine*. 1999. available from www.netdoctor.co.uk and www.migraine-disability.net.

Wilkinson M, MacGregor A. *Understanding migraine & other headaches*. Banbury: Family Doctor Publications, 1999.

Websites:

Migraine Action Association:
www.migraine.org.uk
Patient booklet:
www.netdoctor.co.uk
www.migraine-disability.net

Diagnosis of migraine and other headache subtypes

Overview: Diagnostic screening and differential diagnosis

A short series of four questions is used to screen patients with headache at their first visit to the clinic (Figure 2):

- What is the impact of the headache on the sufferer's daily life? *(high impact = migraine or chronic daily headache; low impact = episodic tension-type headache)*
- How many days of headache does the patient have every month? *(>15 days = chronic headache; <15 days = intermittent migraine)*
- For patients with chronic daily headache, on how many days per week does the patient take analgesic medications? *(≥2 = analgesic-dependent headache; <2 = non- analgesic-dependent headache)*
- For patients with migraine, does the patient experience reversible sensory symptoms associated with their attacks? *(yes = migraine with aura; no = migraine without aura. N.B. Aura occurs in only about 10% of migraine attacks, and most sufferers also experience attacks of migraine without aura.)*

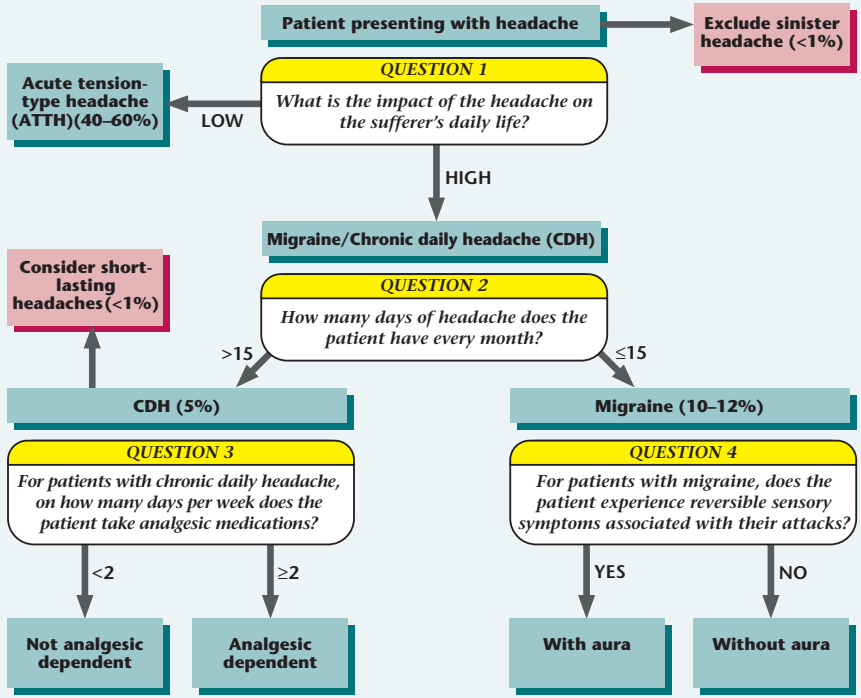


*Figure 2. New MIPCA screening questionnaire for the differential diagnosis of headache (click **here** to open a larger version)*

Exclude sinister headaches

Sinister headaches should be excluded before asking the questions. Points indicating sinister headaches requiring referral include new-onset, acute headaches associated with a range of other symptoms (e.g. rash, neurological deficit, vomiting [not migraine-related] and pain or tenderness, accident or head injury, infection or hypertension) and neurological change/deficit does not disappear when the patient is pain-free between headache attacks (Figure 3).

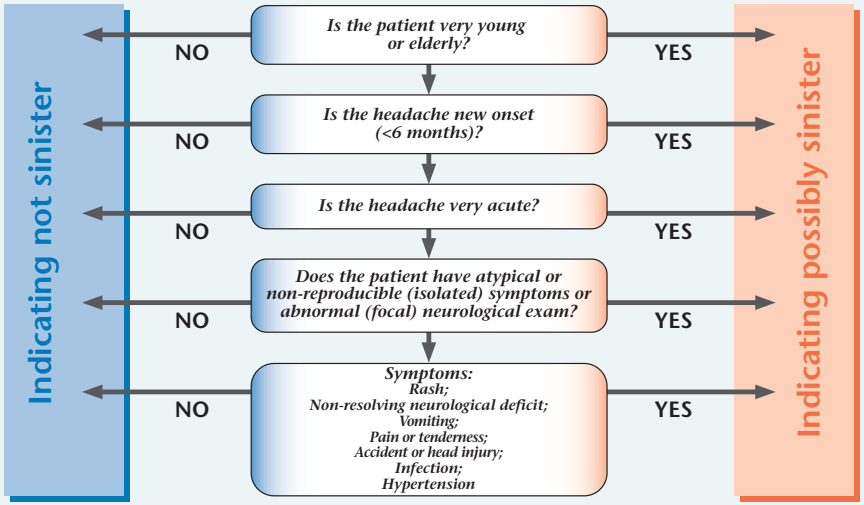


*Figure 3. A simplified algorithm for the identification of patients with suspected sinister headaches (click **here** to open a larger version)*

Impact questionnaires

Two questionnaires have been developed to assess the impact that migraine (and headache in general) has on the sufferer's lifestyle: the Migraine Disability Assessment (MIDAS) Questionnaire, which assesses the disability caused by the headache; and the Headache Impact Test (HIT), which assesses impact as a composite measure of several assessments.

Both MIDAS and HIT have been tested extensively and shown to be reliable and valid, with wide potential for clinical utility. They can be used to:

- Improve communication between patients and their physicians on the impact of migraine.
- Help the physician to assess illness severity.
- Help the physician to produce an individualised treatment plan for each patient, when used with other clinical assessments.

In addition, MIDAS is sensitive to change and can be used to provide an outcome measure to monitor the success of interventions. HIT, unlike MIDAS, can be used as a diagnostic tool to differentiate between headache subtypes. Both questionnaires can be recommended to primary care physicians as aids to the management of migraine and other headaches.

The MIDAS Questionnaire

MIDAS is a paper-based questionnaire, designed to be accessible at physicians' surgeries and pharmacies (information available at www.migraine-disability.net). Migraine sufferers answer five disability questions in three activity domains covering the previous 3-month period (Figure 4). They score the number of lost days due to headache in employment, household work and family and social activities. Sufferers also report the number of additional days with significant limitations to activity (defined as at least 50% reduced productivity) in the employment and household work domains. The total MIDAS score is obtained by summing the answers to the five questions as lost days due to headache. This can sometimes be higher than the actual number of lost headache days due to any one day being counted in more than one domain. The score is categorised into four severity grades:

- Grade I = 0–5 (defined as minimal or infrequent disability).
- Grade II = 6–10 (mild or infrequent disability).
- Grade III = 11–20 (moderate disability).
- Grade IV = 21 and over (severe disability).

Two other questions (A and B) are not scored, but are designed to provide the physician with further information on migraine severity, specifically headache frequency and pain intensity.

This form can help you and your doctor improve the management of your headaches

Do You Suffer From

headaches?

MIDAS QUESTIONNAIRE

INSTRUCTIONS: Please answer the following questions about ALL your headaches you have had over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

1 On how many days in the last 3 months did you miss work or school because of your headaches? ☐☐ days

2 How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school)* ☐☐ days

3 On how many days in the last 3 months did you not do household work because of your headaches? ☐☐ days

4 How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days you counted in question 3 where you did not do household work)* ☐☐ days

5 On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches? ☐☐ days

TOTAL ☐☐ days

A On how many days in the last 3 months did you have a headache? *(If a headache lasted more than 1 day, count each day)* ☐☐ days

B On a scale of 0–10, on average how painful were these headaches? *(Where 0 = no pain at all, and 10 = pain as bad as it can be)* ☐

©Innovative Medical Research 1997

Once you have filled in the questionnaire, add up the total number of days from questions 1–5 (ignore A and B).

Grading system for the MIDAS Questionnaire:

Grade	Definition	Score
I	Minimal or infrequent disability	0–5
II	Mild or infrequent disability	6–10
III	Moderate disability	11–20
IV	Severe disability	21+

MIDAS
www.midas-migraine.net

The MIDAS programme is sponsored by

AstraZeneca

*Figure 4. The Migraine Disability Assessment (MIDAS) Questionnaire. The MIDAS Programme was developed by Innovative Medical Research Inc, with sponsorship and assistance from AstraZeneca (click **here** to open a full version)*

The HIT Questionnaire

HIT was first developed as a web-based test, designed to be accessible to all physicians and headache sufferers through the Internet (at www.headachetest.com and www.amIhealthy.com). This is a dynamic questionnaire, with items derived from four validated headache questionnaires sampling all areas of headache impact. Patients are questioned until clinical standards of score precision are met. In practice, five questions are sufficient to grade the majority of headache sufferers with severe, moderate or mild headache. Internet-HIT differentiates sufferers on the basis of diagnosis and characteristics such as headache severity and frequency, and takes only 1–2 minutes to complete.

HIT-6™ is a paper-based, short-form questionnaire based on the Internet-HIT question pool, designed for people without access to the Internet (Figure 5). Six questions cover pain severity, loss of work and recreational activities, tiredness, mood alterations and cognition. Each question is scored on a five-point scale, with the scores being added to produce the final score. HIT-6™ scores are categorised into four grades, representing minimal, mild, moderate and severe impact due to headache. Internet-HIT and HIT-6™ scores compared well to each other when the two forms of the questionnaire were tested on a group of headache sufferers.

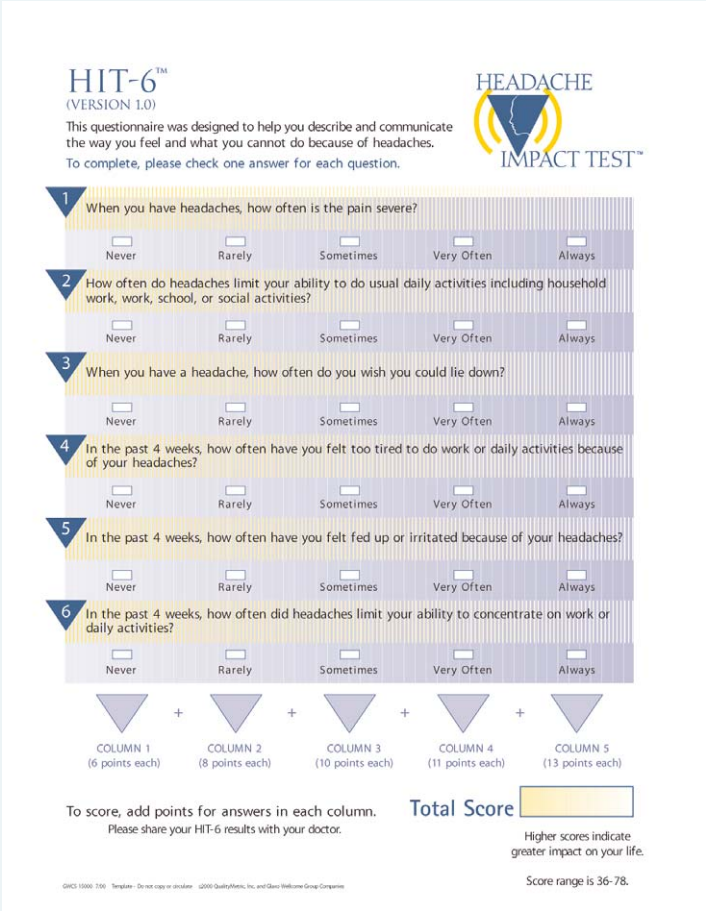


*Figure 5. The Headache Impact Test (HIT-6™). HIT was developed by QualityMetric Inc and GlaxoSmithKline (click **here** to open a larger version)*

Confirm migraine diagnosis

The key question to ask is Question 1, the impact of the headache to the patient's daily life. Any high impact, intermittent headache can be given a default diagnosis of migraine. Further questioning can then be used, if necessary, to confirm the diagnosis (e.g. Table 1).

Part A. Headache symptoms

Symptom	Yes	No
Moderate or severe pain		
Pain on one side of the head		
Pulsating or throbbing pain		
Pain aggravated by normal physical activities		

Part B. Other symptoms

Symptom	Yes	No
Presence of nausea or vomiting		
Tendency to avoid light, noise and odours		

Table 1. A simple questionnaire, based on the IHS diagnostic criteria, to diagnose migraine.

Migraine is diagnosed if the patient indicates 'yes' to two or more items in Part A and one or more questions in Part B.

Diagnose short-lasting headache

Once a pattern of chronic headaches is established (Question 2), the physician should investigate whether short-lasting headaches (e.g. cluster headache or short, sharp headaches) are the cause. These headaches may be confused with migraine, but can be distinguished by their characteristic diagnostic features:

Short sharp headaches

- Very short lived (usually <30 seconds)
- 'Bruised' feeling
- Multiple daily attacks
- Often triggered by eating cold foods ('ice pick' or 'ice cream' headaches)
- Mostly occurs in young to middle-aged adults.

Cluster headache

- Excruciating unilateral headache lasting 15–180 minutes
- Multiple daily attacks
- Male predominance
- Red, watering eye and blocked nose on the headache side.

Links

'10 Commandments':

Impact questionnaires: see Commandments 2 4 5 7

Diagnosis: see Commandments 1 2

References:

Dowson AJ. Assessing the impact of migraine. Curr Med Res Opin 2001;17:298–309.

Dowson AJ, Cady RK. *Rapid Reference to Migraine*. Mosby: London, 2002.

Dowson AJ. Your Questions Answered: Migraine and Other Headaches. Churchill Livingstone: Edinburgh, 2003.

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.

Dowson AJ, Sender J, Lipscombe S et al. Establishing principles for migraine management in primary care. Int J Clin Pract 2003;57:493–507.

Websites:

MIDAS Questionnaire: www.migraine-disability.net

HIT Questionnaire: www.amIhealthy.com or www.headachetest.com

Assessment of illness severity

Each patient should have their migraine severity assessed in terms of:

- Attack frequency and duration.
- Pain severity.
- Impact (using the MIDAS or HIT questionnaire).
- Non-headache symptoms.
- Their history, treatment preferences and concomitant illnesses.
- The practice nurse, if available, can usually collect this information.

Depending on their severity, migraine attacks should be divided into mild-to-moderate and moderate-to-severe intensity (Table 2).

Mild-to-moderate migraine	Moderate-to-severe migraine
Headaches are almost always mild-to-moderate in intensity	Headaches that frequently develop to moderate or severe in intensity
Non-headache associated symptoms, if present are not severe in intensity	Significant non-headache associated symptoms, which may be severe in intensity
The impact of the headache on the patient's lifestyle is not significant: ■ MIDAS Grade I or II (minimal or mild disability) ■ HIT Grade 1 or 2 (minimal or mild impact)	The impact of the headache on the patient's lifestyle is significant: ■ MIDAS Grade III or IV (moderate or severe disability) ■ HIT Grade 3 or 4 (moderate or severe impact)

Table 2. Criteria for assessing patients' migraine as mild-to-moderate or moderate-to-severe.

Links

'10 Commandments':

See Commandment 4

Other fields:

See 'Impact Questionnaires' field

References:

Dowson AJ, Cady RK. *Rapid Reference to Migraine*. Mosby: London, 2002.

Dowson AJ. Your Questions Answered: Migraine and Other Headaches. Churchill Livingstone: Edinburgh, 2003.

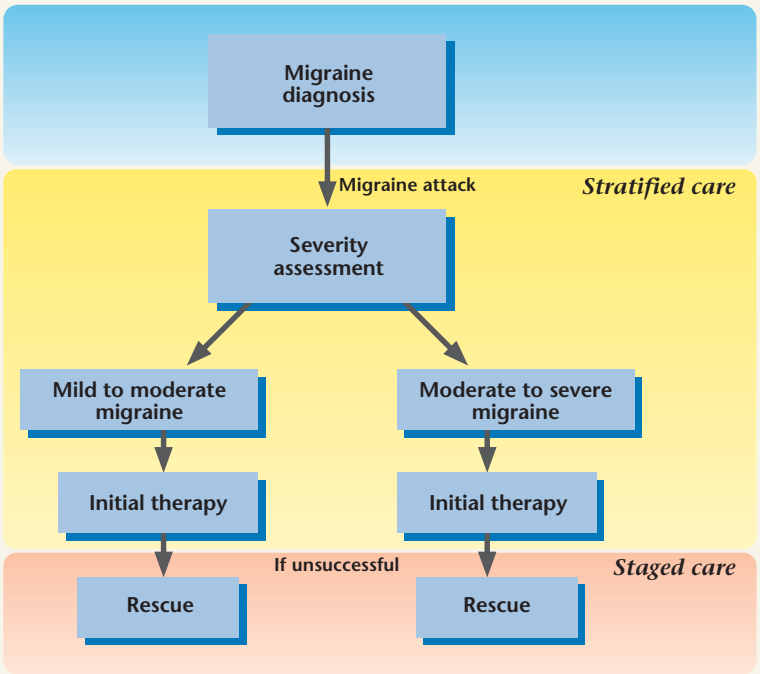
Dowson AJ, Lipscombe S, Sender J et al. New guidelines for the management of migraine in primary care. Curr Med Res Opin 2002;18:414–39.

Lipscombe S, Rees T, Dowson AJ. Tailoring migraine management in primary care to the needs of the individual patient. Headache Care 2003;1: in press.

Initial treatment of the patient – Strategy

Acute medications

- Acute medications should be provided for all patients:
  - Patients should be given a portfolio of acute medications, to treat attacks of differing severities and provide rescue medication if the initial therapy fails (staged care). (Figure 6)
- **Goals of therapy:** Acute medications should rapidly relieve the headache and other symptoms of migraine and permit the return to normal activities within 2 hours of treatment.



Prophylactic medications

- Prescribed prophylactic medications should be provided as additional medications for patients who:
  - Have frequent high-impact migraine attacks (≥4 per month)
  - Do not achieve satisfactory treatment with acute medications
  - Have concomitant conditions that preclude the use of acute medications (e.g. the rare migraine variants)
  - Overuse headache medications and/or have chronic daily headache.
- Behavioural and physical prophylactic therapies should be recommended for all patients.
- Some complementary medications may be used in addition to patients' existing acute and prophylactic therapies.
- **Goals of therapy:** Prescribed prophylactic medications should reduce headache frequency by >50%.

*Figure 6. Strategy for prescribing acute medications for individualised migraine care (click **here** to open a larger version)*

Choice of acute medications

Analgesic-based therapies and an appropriate triptan form the logical choices for initial medications. In general:

- Analgesic-based therapies may be effective for mild-to-moderate attacks.
  - They should be taken as early as possible (preferably before the development of the headache).

- Triptans are useful for:
  - Moderate-to-severe attacks
  - Patients who find analgesic-based medications ineffective.

They can be taken at any time following the development of the headache, but preferably early, when the headache is mild in intensity.

The circumstances for prescribing the different triptan formulations are shown in Table 3.

Patient feature	Initial medication
Analgesic-based therapies ineffective	Oral triptan
Predictable moderate-to-severe attacks, with no significant GI symptoms	Oral triptan
Unpredictable attacks / lifestyles Preference for convenient formualtion	ODT* triptan
Fast onset attacks requiring a rapid onset of relief Severe, high-impact attacks Significant nausea Preference for a non-oral / non-injection formulation	Nasal spray triptan
Fast-onset attacks requiring a rapid onset of relief Severe, high-impact attacks Severe nausea or early vomiting Preference for an injection formulation	Subcutaneous triptan

* ODT = orally disintegrating tablet formulation

Table 3. Appropriate circumstances for prescription of the different triptan formulations.

Individual patient preferences

Patients' subjective preferences for, and satisfaction with, migraine medications are important factors in the success of interventions. Studies have shown that patients often experience inadequate relief from their migraine medications. When asked about their subjective judgements on their migraine drugs, patients report that the headache relief is too slow, the overall relief is inadequate, the headache returns following an initial relief and there are too many side effects. On evaluating several patient preference studies, several trends become apparent. Patients report that they want:

- A greater speed of action
- Enhanced overall effectiveness
- A restored ability to function
- Fewer side effects
- Greater satisfaction with therapy
- Greater convenience of use with their anti-migraine drugs.

Patient preference has been identified as a key factor in the choice of appropriate migraine medication in treatment guidelines.

In everyday clinical practice, this translates into a need to choose therapies that are practical for the patient's use, wherever possible:

- Patients with unpredictable attacks may find the orally disintegrating tablet (ODT) triptan formulations more practical to use than the conventional tablets.
- Those with fast-onset attacks, or who have attacks with associated severe nausea or vomiting may benefit from the nasal spray or subcutaneous triptan formulations.
- Patients who are contraindicated from using triptans or who prefer daily control may be best managed with prophylaxis as their primary treatment, using non-triptan acute medications for rescue only.
- On the other hand, some patients are non-compliant, or have too many side effects with daily prophylaxis. In these cases, management with a portfolio of acute medications may offer the best option.

The physician should always ask the patient about their satisfaction with therapy at follow-up visits. Patients have very individual preferences for medications, which cannot necessarily be predicted in advance. Migraine patients frequently lapse from care following initial therapy, and eliciting patient satisfaction with treatment may help to reduce this problem.

Choice of rescue medications

With the individualised care strategy, 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. The circumstances when such medications should be used are summarised in Table 4.

Patient feature	Initial medication	Rescue medication
Mild-to-moderate attacks	Analgesic-based	2nd dose Oral triptan
Analgesic-based therapies ineffective	Oral triptan	2nd dose Alternative oral triptan Nasal spray / subcutaneous triptan
Predictable moderate-to-severe attacks, with no significant GI symptoms	Oral triptan	2nd dose Alternative oral triptan Nasal spray / subcutaneous triptan
Unpredictable attacks / lifestyles Preference for convenient formualtion	ODT* triptan	2nd dose Nasal spray / subcutaneous triptan
Fast-onset attacks requiring a rapid onset of relief Severe, high-impact attacks Significant nausea Preference for a non-oral / non-injection formulation	Nasal spray triptan	2nd dose Subcutaneous triptan
Fast onset attacks requiring a rapid onset of relief Severe, high-impact attacks Severe nausea or early vomiting Preference for an injection formulation	Subcutaneous triptan	2nd dose Symptomatic treatment

* ODT = orally disintegrating tablet

Table 4. Appropriate circumstances for prescription of rescue medications.

Please use the 'next screen' button to continue 'Choice of rescue medications'

Some general recommendations can be made:

- Patients should have the option of taking a second dose of their initial medication.
- An oral triptan may be used when analgesic-based medications fail.
- A second oral triptan may be tried if the first is ineffective.
- Patients who fail on an oral triptan may experience relief with an ODT, nasal spray or subcutaneous triptan.
- When acute medications fail, symptomatic relief may be necessary for uncontrollable symptoms. Anti-emetics may be given to patients with severe nausea and vomiting. Opiate analgesics (e.g. codeine) may be effective for patients with refractory severe headache and hypnotics may be useful to induce sleep. Use of the latter two types of drugs needs to be monitored carefully, to avoid the possibility of habituation.

However, the physician needs to be cautious for patients who regularly use rescue medications.

- The prescribed formulation of initial medication should be reviewed for patients who frequently use rescue medication.

The physician should be careful that patients do not use excessive doses of acute medications and run the risk of developing CDH.

Chronic Daily Headache (CDH)

Migraine may transform into different headache types over time. A common condition is when migraine transforms into CDH after several years of treatment. CDH is commonly caused by migraine attacks becoming more frequent, a previous head injury or through the overuse of symptomatic headache medications (usually analgesics, ergots and triptans), when it is called 'medication overuse headache' (MOH). In migraine sufferers, MOH can present as daily migraine-like headaches, an increased frequency of the original migraine attacks or as daily tension-type headache (TTH)-like headaches.

CDH should be suspected if the patient has a history of headaches lasting over 4 hours and occurring on more than 15 days per month. The physician should be aware of the risks of their migraine patients developing CDH, and should monitor their use of symptomatic headache medications. As a rule of thumb, it has been suggested that patients should take no more than:

- Two triptan doses per attack and 12 doses per month
- 4 mg of ergotamine per attack and 20 mg per month
- 1,000 mg of simple analgesics per attack on ≤2 days per week.

In general, patients should not receive migraine drugs containing barbiturates, codeine or other opioids, tranquillizers and mixed analgesics without strict supervision.

The principles of treating CDH are as follows:

- Physical exercises and/or physiotherapy to the neck
- Withdrawal of headache medications that the patient is abusing (≥2 days of use per week)
- Initiate a prophylactic medication to prevent the development of headaches. Effective drugs include antidepressants (e.g. dothiepin and amitriptyline) and anticonvulsants (e.g. sodium valproate, gabapentin and topiramate).
- Provide an acute medication to treat breakthrough headache attacks. This can be a triptan if the patient has a history of migraine attacks.
- Referral to a specialist may be required if these initiatives fail.

When present, CDH and MOH are usually best treated in a specialist headache centre, to which the patient should be referred. Successful treatment often leads to the re-emergence of the original episodic pattern of migraine attacks, which can then be managed in the conventional way in primary care.

Choice of prophylactic medications

Prescribed prophylactic medications

- In the absence of contraindications, the obvious first-line migraine prophylactic drug is a beta-blocker (propranolol, metoprolol, timolol or nadolol)
  - The aim should be to start with a low dose and titrate up till an effective dose is reached. This may take from several weeks to 3 months.
- If a beta-blocker is not appropriate, serotonin antagonists (pizotifen and methysergide), the anticonvulsant sodium valproate* or the antidepressant amitripyline* may be effective.

* Not currently licensed for migraine in the UK.

Behavioural and physical therapies

- Biofeedback, relaxation therapy, stress reduction, avoidance of triggers, cervical manipulation, massage or exercise may all be used as preventive drugs and can be recommended for all patients.

Complementary therapies

- Feverfew, magnesium, vitamin B2, butterbur and acupuncture may all act to prevent migraine attacks. The physician can recommend these therapies be used in addition to patients' usual acute and prophylactic medications, but the patient should be advised to consult an accredited practitioner only.

Recommended medications

An initiative by the US Headache Consortium and Duke University, North Carolina, USA, has led to the development of evidence-based rating of the efficacy and safety of anti-migraine drugs. Acute and prophylactic drugs, behavioural and physical therapies and complementary medications are all covered.

Based on these analyses, the following tables (Tables 5–8) rate the medications available in the UK according to their evidence of efficacy and safety for the treatment of migraine. In each case, medications listed in the left-hand column have objective evidence of favourable efficacy and safety, and can be recommended for use as first-line therapies.

Favourable efficacy and tolerability confirmed by large, well-designed clinical studies	Efficacy not confirmed in large clinical studies, or, efficacy compromised by safety concerns	Evidence indicates that the drug is not effective for migraine
Aspirin* and NSAIDs (Voltarol Rapid®, Clotam Rapid® and Synflex®)	Paracetamol plus codeine (Solpadeine®*; Migraleve®)	Paracetamol monotherapy*
Paracetamol plus domperidone (Domperamol®)	Opiate analgesics*	Anti-emetics as monotherapy*
Aspirin or paracetamol plus metoclopramide (Migramax®; Paramax®)	Barbiturates*	Oral ergotamine (Cafergot®; Migril®)
Isometheptene plus paracetamol (Midrid®)	Ergotamine suppositories (Cafergot Suppos®)	
Triptans: Sumatriptan (po, in, sc) (Imigran®) Naratriptan (po) (Naramig®) Zolmitriptan (po, in) (Zomig®) Rizatriptan (po) (Maxalt®) Almotriptan (po) (Almogran®) Eletriptan (po) (Relpax®) Frovatriptan (Migard®)		

Table 5. Clinical profiles of acute migraine therapies available in the UK, based on the Duke database.

**Not licenced for migraine in the UK.*

Favourable efficacy and tolerability confirmed by large, well-designed clinical studies	Efficacy not confirmed in large clinical studies, or, efficacy compromised by safety concerns	Evidence indicates that the drug is not effective for migraine
Beta-blockers: propranolol (Beta-Prograne®, Inderal LA®, Syprol®), metoprolol (Betaloc®, Lopresor®), timolol (Betim®), nadolol (Corgard®)	Serotonin antagonists: methysergide (Deseril®), cyproheptadine (Periactin®), pizotifen (Sanomigran®)	Central alpha agonist: clonidine (Dixarit®)
Anticonvulsants*: sodium valproate** (Depakote®)		
Antidepressants*: amitriptyline** (Lentizol®)		

* Not licensed for migraine prophylaxis in the UK
** Also shown to be effective in the treatment of CDH

Table 6. Clinical profile of prophylactic migraine treatments available in the UK, based on the Duke database.

Favourable efficacy confirmed in clinical studies	Efficacy not confirmed in clinical studies
Behavioural therapy Biofeedback Relaxation therapy Stress reduction Avoidance of migraine triggers	**Behavioural therapy** Avoidance of foodstuffs
Physical therapies Cervical manipulation Massage + stress reduction Exercise + stress reduction	**Physical therapies** Hypnosis TENS Occlusal adjustment Hyperbaric oxygen

Table 7. Clinical profile of behavioural and physical therapies for migraine, based on the Duke database.

Favourable efficacy confirmed in clinical studies	Efficacy not confirmed in clinical studies
Feverfew	Low-dose aspirin
Magnesium	Homeopathic medications
Vitamin B2	Aromatherapy
Butterbur	Food exclusion diets following identification of food intolerances
Acupuncture	

Table 8. Clinical profile of complementary therapies for migraine identified in clinical studies.

Links

'10 Commandments'

Strategy: see Commandment 4

Patient preference: see Commandment 10

Choice of acute medication: see Commandment 7

Choice of rescue medication: see Commandment 4

Chronic daily headache: see Commandments 5 6 9

Choice of prophylactic medication: see Commandment 8

References:

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.

Lipscombe S, Rees T, Dowson AJ. Tailoring migraine management in primary care to the needs of the individual patient. Headache Care 2003;1: in press.

Matchar DB, Young WB, Rosenberg JH et al. Multispecialty consensus on diagnosis and treatment of headache: pharmacological management of acute attacks. Neurology 2000;54: www.aan.com

Ramadan NM, Silberstein SD, Freitag FG et al. Multispecialty consensus on diagnosis and treatment of headache: pharmacological management for prevention of migraine. Neurology 2000;54: www.aan.com

Campbell JK, Penzien DP, Wall EM. Evidence-based guidelines for migraine headache: behavioural and physical treatments. Neurology 2000;54: www.aan.com

Follow-up treatment

Migraine attacks typically occur for several decades of the sufferer's life, and long-term management of the condition should therefore be mandatory. After the first consultation, the patient should be asked to return to the surgery on a regular basis for review. The patient can be asked to complete questionnaires that can help in the monitoring of care:

- A headache diary should be used to capture the patient's pattern of headaches over time.
- Impact questionnaires (MIDAS and HIT) can capture the impact of migraine over time and may also be useful in assessing the response to therapy.
- The practice nurse, if available, can often collect this information.

The efficacy of acute and prophylactic medications should be monitored at each clinic visit.

Headache diaries

Several headache diaries are available, some being produced by pharmaceutical companies. Until a definitive diary is available (currently under development by MIPCA and MAA), GPs should obtain a suitable diary from visiting representatives. In general, they collect the following information:

- Record of appointments (to monitor for consultations attended and missed, and for patients lapsing from care)
- Daily record of headaches experienced, together with their duration and severity
- Any experience of non-headache symptoms coincident with the headache
- Any identified factors that may have triggered the headache
- Time lost from normal daily activities due to the headache
- Medications taken for the headache and their effectiveness and side effects
- Other concomitant medications taken for non-headache conditions
- Dates of menstrual periods (where appropriate) and other illnesses.

Acute medications

- Patients who are effectively treated should continue with their original medication.
- Patients who fail on their original therapy should be switched to other medications (Table 9).
- Patients who fail on repeated acute medications should be referred to a specialist physician.

Patient feature	Initial medication	Rescue medication	Switch at follow-up (if necessary)
Mild-to-moderate attacks	Analgesic-based	2nd dose Oral triptan	Oral triptan
Analgesic-based therapies ineffective	Oral triptan	2nd dose Alternative oral triptan Nasal spray / subcutaneous triptan	Alternative oral triptan Nasal spray / subcutaneous triptan
Predictable moderate-to-severe attacks, with no significant GI symptoms	Oral triptan	2nd dose Alternative oral triptan Nasal spray / subcutaneous triptan	Alternative oral / ODT* triptan Nasal spray / subcutaneous triptan
Unpredictable attacks / lifestyles Preference for convenient formulation	ODT* triptan	2nd dose Nasal spray / subcutaneous triptan Alternative ODT* triptan	Alternative ODT* triptan Nasal spray / subcutaneous triptan
Fast-onset attacks requiring a rapid onset of relief Severe, high-impact attacks Significant nausea Preference for a non-oral / non-injection formulation	Nasal spray triptan	2nd dose Subcutaneous triptan	Subcutaneous triptan Symptomatic treatment Prophylaxis
Fast-onset attacks requiring a rapid onset of relief Severe, high-impact attacks Severe nausea or early vomiting Preference for an injection formulation	Subcutaneous triptan	2nd dose Symptomatic treatment	Prophylaxis Referral

Table 9. *Appropriate circumstances for switching of acute medications at follow-up.*

* ODT = orally disintegrating tablet

Prophylactic medications

- Prophylaxis is not intended as a long-term management strategy, but should be reviewed from 4–6 weeks after initiation.
- If the treatment is effective, without causing chronic side effects, treatment can be continued up to 6 months. If not, the dose can be increased (up to the maximum allowed) or an alternative prophylactic drug can be supplied.
- At 6 months, the prophylactic drug can be withdrawn if the frequency of attacks is reduced. Providing the frequency remains reduced after withdrawal, it may be appropriate to revert to acute treatments only (Figure 7).

In general:

- Ensure that the patient is comfortable with the treatment recommended and that it is practical for their lifestyle and headache presentation.
- Monitor for the possible development of CDH.
- Patients who do not respond to repeated courses of acute and prophylactic medications should be referred to a neurologist or headache specialist for care.

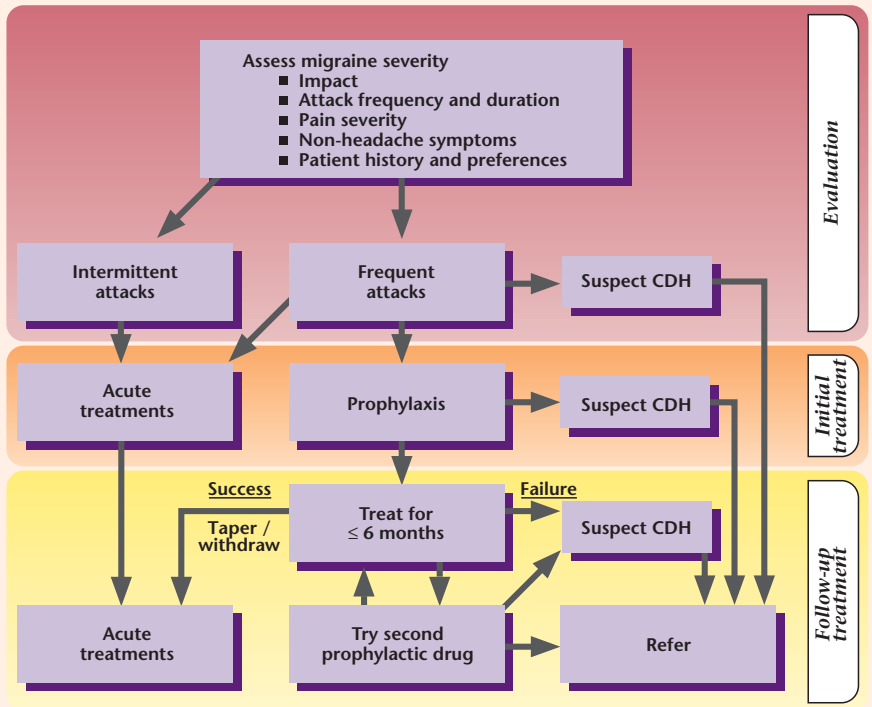


Figure 7. Monitoring of prophylactic medications at follow-up (click here to open a larger version)

Reasons for referral

The majority of headache patients can be managed successfully in primary care. However, there are certain circumstances where the GP needs to refer the patient to a headache specialist or consultant neurologist with a special interest in headache:

- The patient has suspected sinister headache
- The GP is unsure of the diagnosis
- The patient has suspected cluster headache
- The patient has suspected CDH
- The patient is suspected of having one of the rare migraine variants
- The patient has migraine that is resistant to repeated administrations of different acute and prophylactic medications.

Links

'10 Commandments'

Diaries: see Commandments 5 6

Acute medications: see Commandment 10

Prophylactic medications: see Commandments 9 10

Referral: see Commandments 1 7 9

Other fields:

See Impact Questionnaires field

See Patient Preference field

See Chronic Daily Headache field

References

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.

Dowson AJ, Sender J, Lipscombe S et al. Establishing principles for migraine management in primary care. Int J Clin Pract 2003;57:493–507.

Lipscombe S, Rees T, Dowson AJ. Tailoring migraine management in primary care to the needs of the individual patient. Headache Care 2003;1: in press.

Managing migraine in the clinic

The primary care headache team

The management of migraine in primary care is, of necessity, a long-term business. Patients need to be evaluated and treated carefully over a period of time. The physician's time and energy can be conserved during this process by utilising the skills of other healthcare providers to form a primary care headache team (Figure 8). The physician, practice nurse, ancillary clinic staff and sometimes a pharmacist provide the core team. Pharmacists, community nurses, opticians, dentists and complementary practitioners can all feed patients into the team, while the physician can refer the patient to a specialist physician if necessary.

The GP and specialist physician

The GP can concentrate on the patient's diagnosis and initial and follow-up treatments, referring them to a specialist, if necessary. Good communication needs to be established between the specialist and primary care physicians. The specialist needs to inform the primary care physician of their diagnosis and treatment choices, as much of the future management of these patients devolves into primary care. The specialist does not have to be a consultant physician. A primary care physician or Primary Care Trust (PCT) specialist with expertise in headache may also be appropriate.

Guidelines for the setting up of specialist headache services in the primary care environment are now available at the Department of Health (DOH) website.

Some form of training is likely to be needed for the team to work optimally in practice. This may include the development of diplomas in headache for GPs, nurses and possibly other professionals. For the healthcare professional with an interest in headache, help can be gained from one of the many professional organisations that deal with headache research and treatment in the UK, e.g. MIPCA, The Migraine Action Association (MAA), Migraine Trust and the British Association for the Study of Headache (BASH).

The nurse

The practice nurse can conduct much of the communication with and evaluation of the patient before they see the physician, and may also meet migraine sufferers serendipitously during their regular duties. They can also conduct much of the recording of data and evaluation of patients throughout the management process, e.g. providing advice and information and reviewing patients' diaries and impact assessments during follow-up. Nurse practitioners can have a similar role in specialist centres.

Pharmacists

Pharmacists can help with the identification, education and initial treatment of headache sufferers, and advise appropriate sufferers to consult their primary care physician. Pharmacists can also explain when drugs (acute and prophylactic) should be taken, and answer patients' concerns about side effects and possible interactions with other products.

Other healthcare professionals

Community nurses, physical therapists, complementary practitioners and other primary healthcare providers who deal with headache sufferers can also be part of the team. They can help with the identification, education and initial treatment of headache sufferers, and advise appropriate sufferers to consult their primary care physician. Professionals such as dentists and opticians will also meet headache sufferers during their normal duties and can feed potential patients into the headache team. Last, but not least, the patient is an important member of the team, and must be included in the treatment decision-making process. The patient needs to be able to discuss their headache history, understand their diagnosis and management plan, and what it is likely to achieve, agree to the course of therapy and feel motivated to continue with long-term treatment.

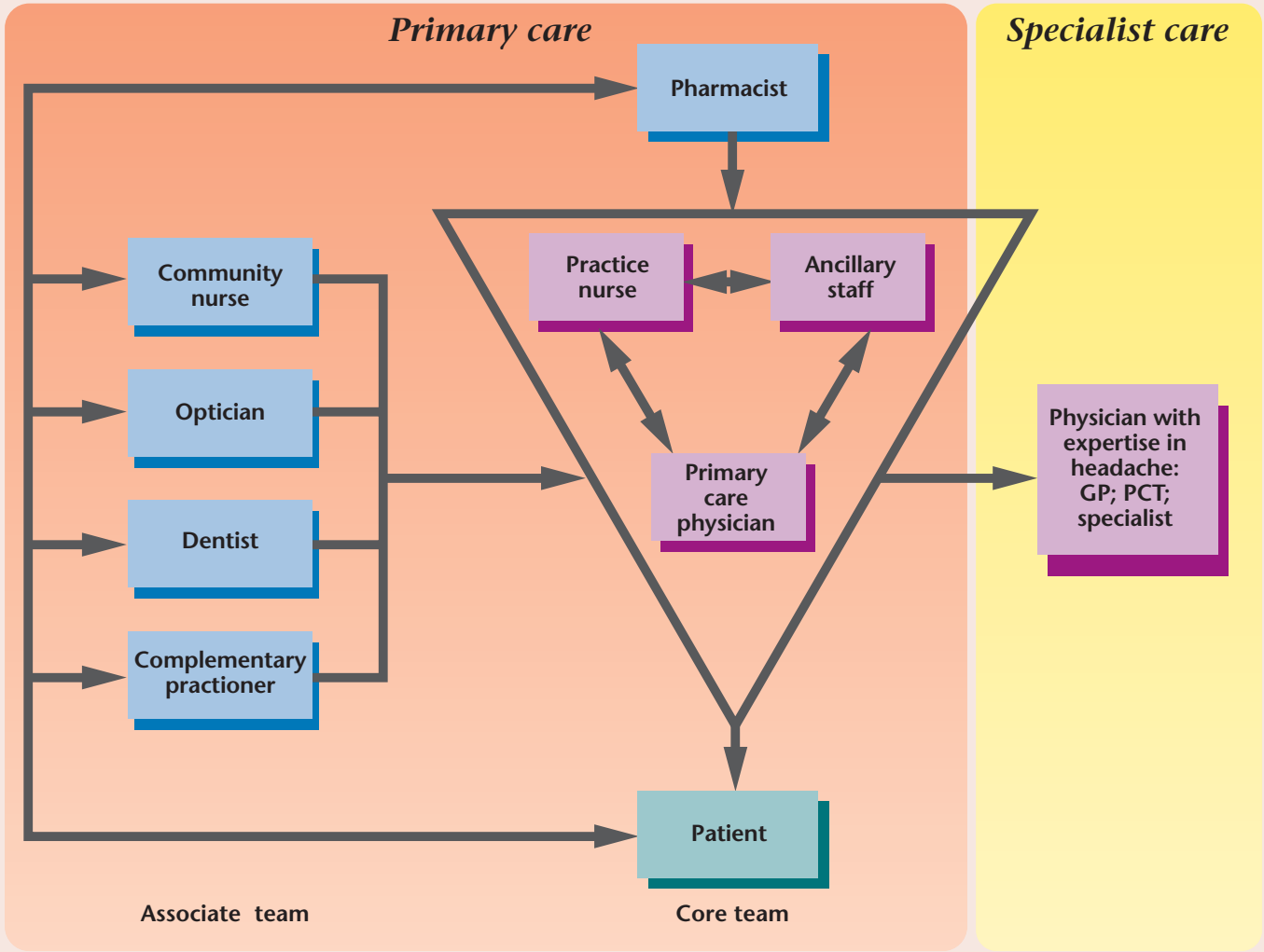


Figure 8. Organisation of headache services in primary care

Links

Websites:

MIPCA: www.mipca.org.uk

MAA: www.migraine.org.uk

Migraine Trust: www.migrainetrust.org

BASH: www.bash.org.uk

DOH: www.doh.gov.uk

References:

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.

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

THE 10 MIGRAINE COMMANDMENTS

SCREENING/DIAGNOSIS

1 *Almost all headaches are benign and should be managed in general practice.*

While almost all headaches encountered in general practice are the common primary headaches of migraine, tension-type headache and chronic daily headache, the physician must screen for the possible (but very rare) occurrence of secondary (sinister) headaches. Points indicating sinister headaches requiring referral include new-onset, acute headaches associated with a range of other symptoms (e.g. rash, neurological deficit, vomiting and pain or tenderness, accident or head injury, infection or hypertension) and neurological change/deficit does not disappear when the patient is pain-free between headache attacks.

return to previous guidelines view

2 *Use questions / a questionnaire assessing impact on daily living for diagnostic screening and to aid management decisions.*

Evidence shows that patients presenting to their GPs with episodic, high impact headaches almost always have migraine. Such patients should be given a default diagnosis of migraine, with the diagnosis confirmed, if necessary, by further questioning. Additionally, migraine may present in these patients with features suggestive of tension-type headache or migrainous headache (where all but one migraine symptom is present), as well as headaches with the characteristic features of migraine. All these headaches can be effectively treated with migraine-specific medications, e.g. the triptans. Two questionnaires, the Migraine Disability Assessment (MIDAS) Questionnaire (www.migraine-disability.net) and the Headache Impact Test (www.amIhealthy.com) can be used to assess impact. To optimise healthcare resources, the practice nurse can apply these questionnaires before the patient sees their GP.

return to previous guidelines view

MANAGEMENT

3 *Share migraine management between the doctor and patient.*

The patient should be encouraged by the GP to take control of their own migraine management. The GP's role is to provide education and guidance, and to encourage the patient to buy-in to a care management process.

return to previous guidelines view

4 *Provide individualised care for migraine and encourage patients to treat themselves.*

Migraine attacks are highly variable in frequency, duration, presenting symptoms and impact, both between different patients and between separate attacks in the individual patient. 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 also deserve rescue medication if 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.

return to previous guidelines view

5 *Follow-up patients, preferably with migraine diaries.*

Proactive follow-up procedures are necessary for the successful long-term management of migraine. The GP should invite the patient to return for further management at regular intervals and monitor the patient's pattern of headaches and outcome of therapy carefully. Headache diaries are freely available and are an invaluable aid for these assessments. Impact questionnaires (MIDAS and/or HIT) are also useful tools in follow-up. To optimise healthcare resources, the practice nurse can apply these diaries and questionnaires before the patient sees their GP.

return to previous guidelines view

6 *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, presenting symptoms and impact, may all change, necessitating changes to management practices. A common condition is when migraine transforms into chronic daily headache (CDH) after several years of treatment. CDH usually presents as daily or near-daily tension-type headaches superimposed over a background of episodic migraine. Causative factors include a history of head injury or the overuse of headache medications, which cause rebound headaches. CDH should be suspected if the patient has a history of headaches lasting over 4 hours on more than 15 days per month. Shorter lasting chronic headaches may be due to cluster headache or short, sharp headaches. In all these cases, chronic headaches are usually best referred to a specialist for management.

return to previous guidelines view

TREATMENTS

7 *Provide acute medication to all migraine patients and recommend it is taken as soon as possible in 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. Aspirin, NSAIDs and analgesic-combination medications may be effective for mild-to-moderate migraine 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 moderate-to-severe attacks and when other acute medications fail. Triptans are 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, codeine and ergotamine should be avoided if possible. However, the intermittent use of codeine-containing preparations may be appropriate.

return to previous guidelines view

8 *Prescribe prophylactic medications to patients who have four or more migraine attacks per month or who are resistant to acute medications.*

Prophylactic medications should be prescribed 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, 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 several weeks or months.

return to previous guidelines view

9 *Monitor prophylactic therapy regularly.*

Prophylaxis is not intended as a long-term management strategy, but should be reviewed from 4–6 weeks. If the treatment is effective, without causing chronic side effects, treatment can be continued up to 6 months. If not, the dose can be increased (up to the maximum allowed) or an alternative prophylactic drug can be supplied. At 6 months, the prophylactic drug can be withdrawn if the frequency of attacks is reduced. Providing the frequency remains reduced after withdrawal, it may be appropriate to revert to acute treatments only. Patients who are refractory to repeated acute and/or prophylactic medications may need to be referred to a specialist for further care.

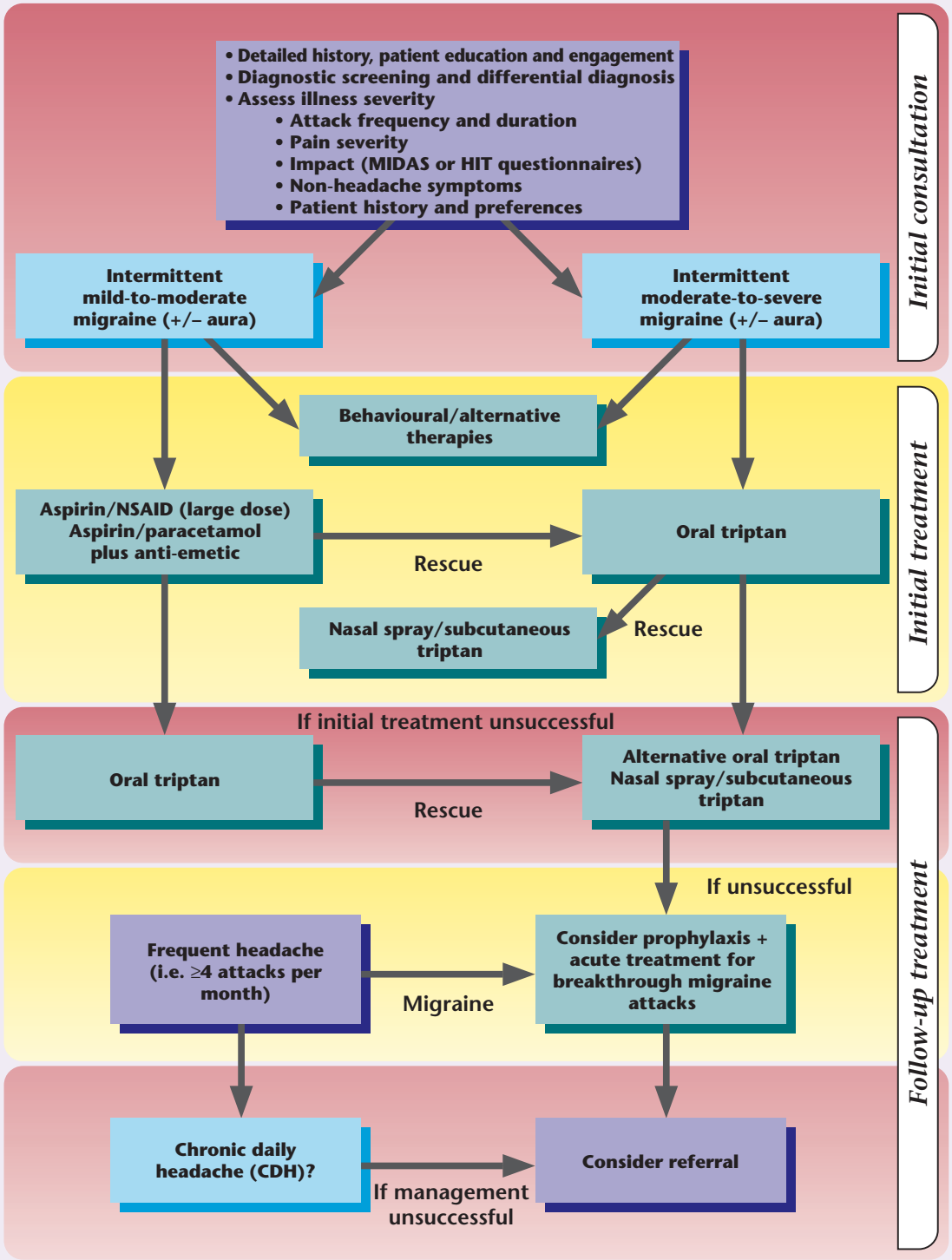
return to previous guidelines view

10 *Ensure that the patient is comfortable with the treatment recommended and 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 GP 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.

Wherever possible, choose therapies that are practical for the patient's use. For example, patients with unpredictable attacks, or those who have attacks with associated severe nausea or vomiting may benefit from the non-oral triptan formulations. Patients who are contraindicated from using triptans may be best managed with prophylaxis as their primary treatment, using non-triptan acute medications for rescue only.

return to previous guidelines view



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MIPCA

MIGRAINE IN PRIMARY CARE ADVISORS

I am interested in joining MIPCA. Please send me the members' information pack and information on future activities. I agree to the information below being held on the MIPCA members' database. This information will not be circulated to anyone outside mipca without the member's permission.

Name _____

Affiliation _____

_____

Contact details _____

_____

_____

email address _____

Professional group (please tick the area that best describes your area of expertise)

GP ☐ Nurse ☐ Pharmacist ☐

Physical therapist ☐

Type of physical therapist _____

Complementary therapist ☐

Type of complementary therapist _____

Other ☐

Please describe the medical service you offer

_____

MIPCA is in the process of putting together various projects relating to several special interest groups. Please tick the boxes below if you are interested in belonging to one or more of these groups.

Education ☐ Research ☐

Running a headache clinic ☐

If so, please specify the type of clinic (e.g. PCT)

_____

return to guidelines print this form next page

Request for feedback

Please use the space below for any further information you wish to supply, e.g. your feedback on MIPCA and ideas for future research and educational initiatives.

Please return the completed questionnaire to the secretariat at:

MIPCA, c/o Surrey Headache Service, Merrow Park Surgery, Kingfisher Drive, Merrow, Guildford GU4 7EP, telephone/fax 01483 450755.

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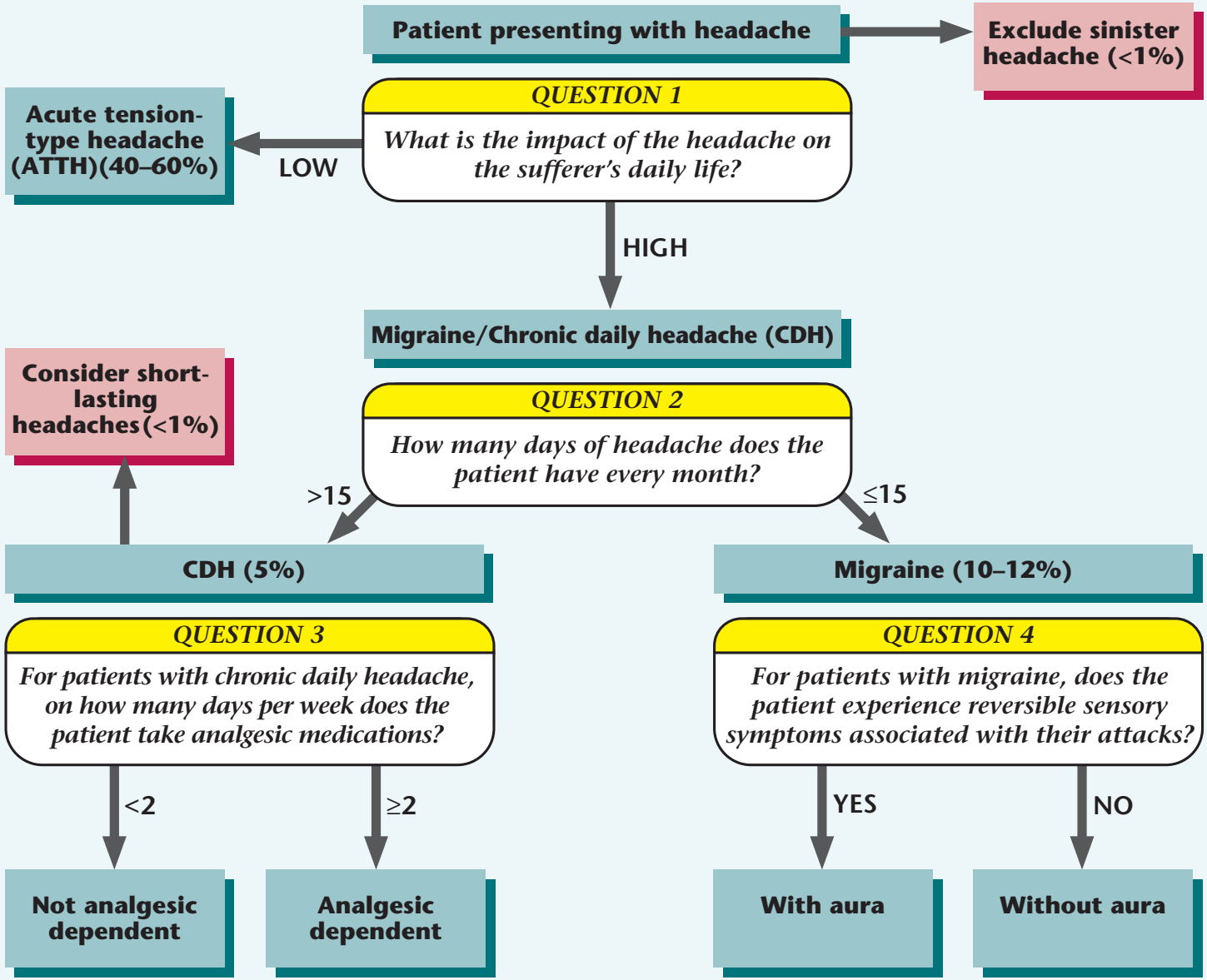
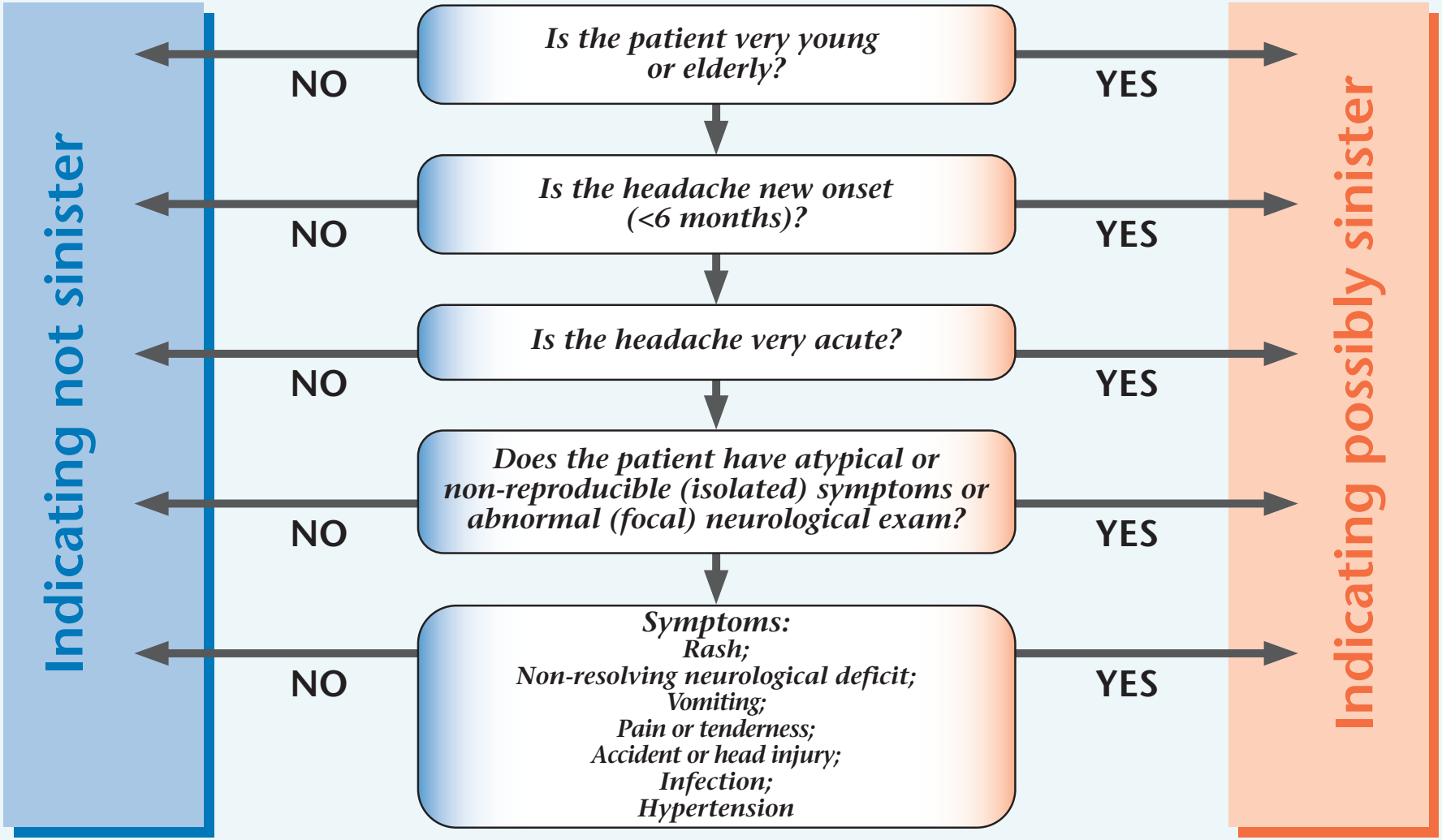

Patient presenting with headache
Exclude sinister headache (<1%)
QUESTION 1
What is the impact of the headache on the sufferer's daily life?
LOW
Acute tension-type headache (ATTH)(40–60%)
HIGH
Migraine/Chronic daily headache (CDH)
Consider short-lasting headaches (<1%)
QUESTION 2
How many days of headache does the patient have every month?
>15
≤15
CDH (5%)
Migraine (10–12%)
QUESTION 3
For patients with chronic daily headache, on how many days per week does the patient take analgesic medications?
QUESTION 4
For patients with migraine, does the patient experience reversible sensory symptoms associated with their attacks?
<2
≥2
YES
NO
Not analgesic dependent
Analgesic dependent
With aura
Without aura


Indicating not sinister
Is the patient very young or elderly?
NO
YES
Is the headache new onset (<6 months)?
NO
YES
Is the headache very acute?
NO
YES
Does the patient have atypical or non-reproducible (isolated) symptoms or abnormal (focal) neurological exam?
NO
YES
Symptoms:
Rash;
Non-resolving neurological deficit;
Vomiting;
Pain or tenderness;
Accident or head injury;
Infection;
Hypertension
NO
YES
Indicating possibly sinister

This form can help you and your doctor improve the management of your headaches

Do You Suffer From

headaches?

MIDAS QUESTIONNAIRE

INSTRUCTIONS: Please answer the following questions about ALL your headaches you have had over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

1	On how many days in the last 3 months did you miss work or school because of your headaches?	0	days
2	How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school)*	0	days
3	On how many days in the last 3 months did you not do household work because of your headaches?	0	days
4	How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days you counted in question 3 where you did not do household work)*	0	days
5	On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?	0	days
	TOTAL	0	days
A	On how many days in the last 3 months did you have a headache? *(If a headache lasted more than 1 day, count each day)*	0	days
B	On a scale of 0–10, on average how painful were these headaches? *(Where 0 = no pain at all, and 10 = pain as bad as it can be)*	0	

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Your MIDAS score...

Grade I - Minimal or infrequent disability (score 0-5)

Grading system for the MIDAS Questionnaire:

Grade	*Definition*	*Score*
I	*Minimal or infrequent disability*	*0–5*
II	*Mild or infrequent disability*	*6–10*
III	*Moderate disability*	*11–20*
IV	*Severe disability*	*21+*

More ...

The MIDAS Questionnaire provides valuable information to help your physician recommend a suitable management strategy for your headaches. We recommend that you take the completed Questionnaire to your physician to obtain suitable treatment.

Print

MIDAS
www.midas-migraine.net

The MIDAS programme is sponsored by AstraZeneca

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reset form

How is the MIDAS Score Interpreted?

The MIDAS score is classified into four grades of severity that predict the patient's treatment needs. See the table below for MIDAS grade definitions, corresponding MIDAS scores and recommendations:

MIDAS Score	MIDAS Grade	Definition	Recommendations
0–5	I	Minimal or infrequent disability	MIDAS Grade I usually indicates low medical need. Simple, over-the-counter analgesics may be effective in the acute treatment of these patients. However, the impact of even a few lost days on the lifestyle of these patients should be assessed. Also, some patients with a MIDAS Grade I, such as those with infrequent, but severe migraine, may benefit from first-line treatment with specific migraine therapies (e.g. triptans). MIDAS Grade I patients who have failed to achieve effective relief with simple analgesics should also be considered for triptan therapy.
6–10	II	Mild or infrequent disability	MIDAS Grade II usually indicates moderate medical need. The patients may require an acute prescription medication. Some MIDAS Grade II patients may also qualify for first-line triptan medication if their headaches are severe. For example, a score of 10 could mean that a patient is missing ten days of school or paid work, so the headaches could be causing severe disruption in their lives. MIDAS Grade II patients should also qualify for first-line triptan medication if they have failed on simple analgesics.
11–20	III	Moderate disability	MIDAS Grade III/IV indicates a high medical need. These patients are experiencing significant disability and their migraine attacks are having a severe impact on their lives. Specific acute therapy, such as a triptan, is usually the most appropriate therapy for these patients, providing they are suitable recipients. Prophylactic treatment should also be considered. Please note that a very high MIDAS score could also indicate a high frequency of non-migraine headache, and these patients should be managed accordingly.
≥21	IV	Severe disability	

HIT-6™
(VERSION 1.0)

HEADACHE IMPACT TEST™

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please check one answer for each question.

1 **When you have headaches, how often is the pain severe?**

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

2 **How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?**

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

3 **When you have a headache, how often do you wish you could lie down?**

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

4 **In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?**

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

5 **In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?**

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

6 **In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?**

☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

▽ + ▽ + ▽ + ▽ + ▽

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
(6 points each)	(8 points each)	(10 points each)	(11 points each)	(13 points each)

To score, add points for answers in each column.

Please share your HIT-6 results with your doctor.

Total Score ____

Higher scores indicate greater impact on your life.

Score range is 36-78.

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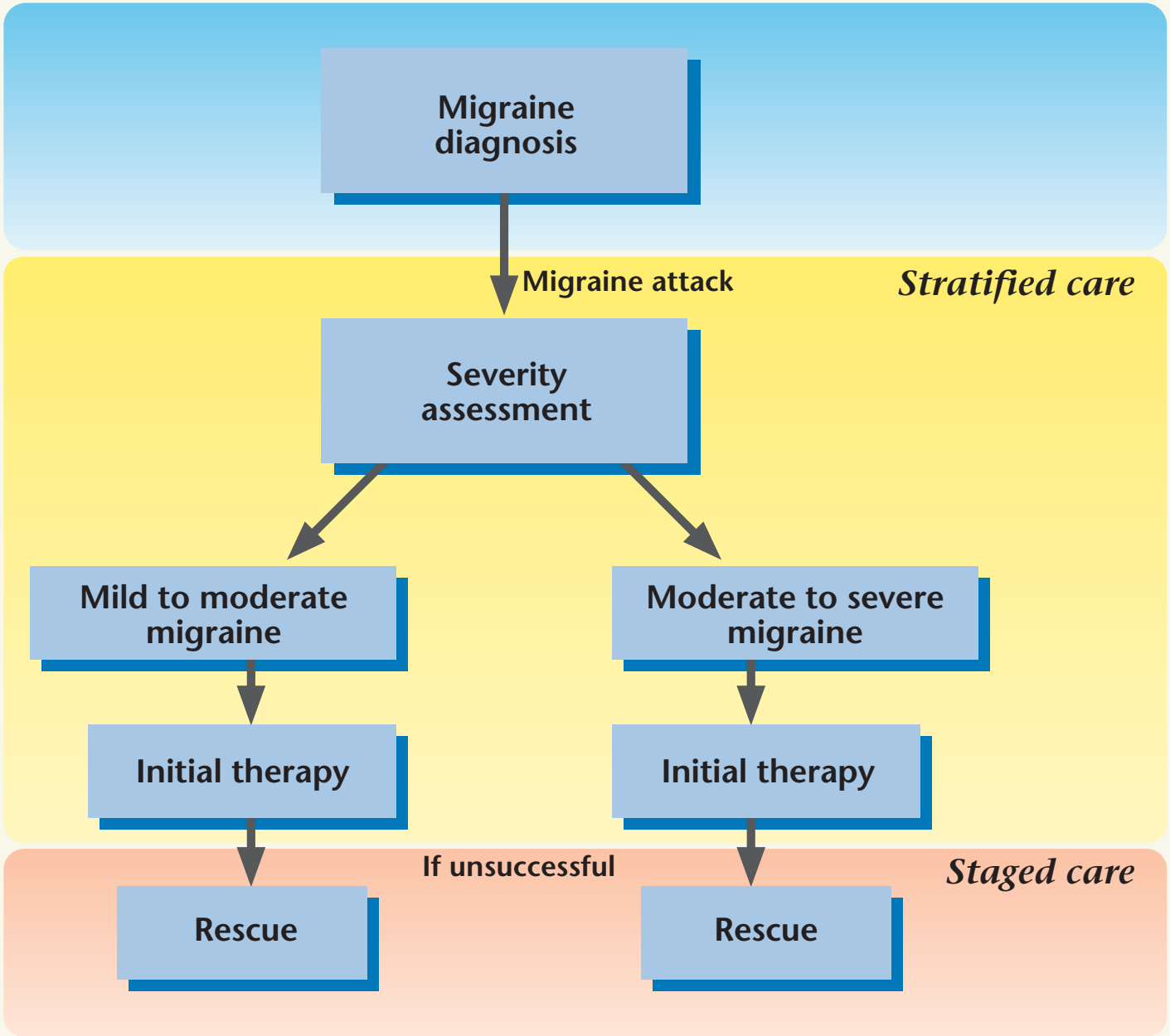
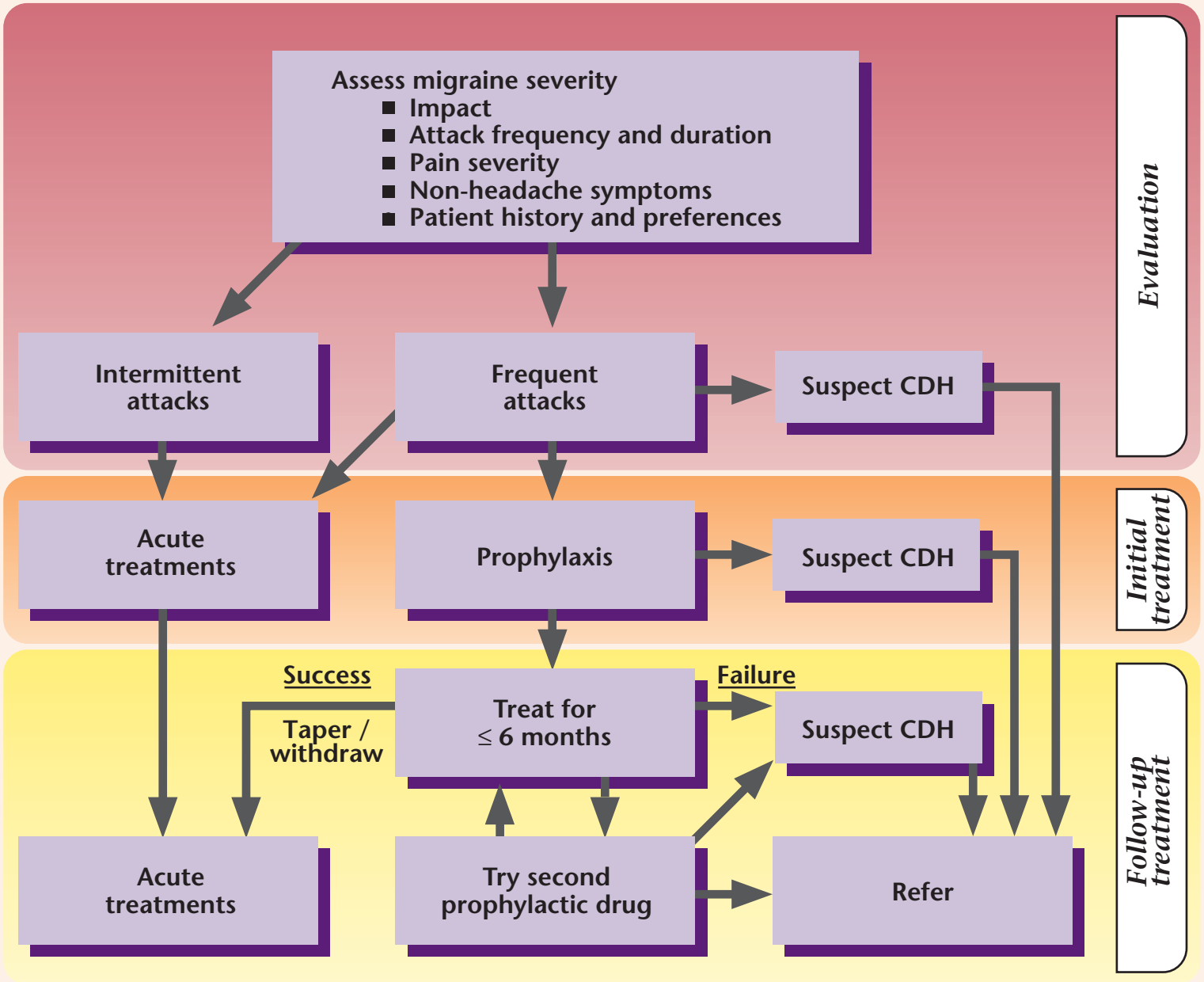

Migraine diagnosis
Migraine attack
Stratified care
Severity assessment
Mild to moderate migraine
Moderate to severe migraine
Initial therapy
Initial therapy
If unsuccessful
Staged care
Rescue
Rescue


Assess migraine severity
Impact
Attack frequency and duration
Pain severity
Non-headache symptoms
Patient history and preferences
Intermittent attacks
Frequent attacks
Suspect CDH
Acute treatments
Prophylaxis
Suspect CDH
Success
Taper / withdraw
Treat for ≤ 6 months
Failure
Suspect CDH
Acute treatments
Try second prophylactic drug
Refer
Evaluation
Initial treatment
Follow-up treatment