

## Three Common Mistakes in Treating the Headache Patient

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### **Presentation Summary**

Three of the most common mistakes in treating patients with migraine are: 1) taking an inadequate history and thereby missing the diagnosis or not acknowledging the patient's concerns; 2) allowing the patient to overuse or misuse medication; and 3) failing to prepare the patient for a long-term course of treatment. The key to preventing or correcting each of these mistakes is establishing, as early as possible, a close physician-patient partnership for treatment. Such a partnership develops during the thorough initial patient interview,

general examination, and screening neurologic assessment—at which time fears of serious organic disease can be addressed. In order to convince the patient of the practitioner's interest in his or her headache problem, one must elicit clinical details while listening to issues of disability, social support, and quality of life. This partnership forms the basis for ongoing patient education on proper medication use and realistic treatment expectations. Only when the patient becomes an active partner in ongoing therapy can the best outcomes be achieved.

In designing treatment guidelines for headache patients, whether the guidelines cover a single initial consultation or an entire tertiary pathway, several basic clinical principles must be remembered. These clinical fundamentals are not difficult, nor are they superfluous niceties in today's 10-minute-per-patient primary care world. They are actually crucial steps toward our goal of promptly and economically reducing the burden of this chronic disease.

Unfortunately, the core clinical skills used to recognize and treat the headache patient are all too often neglected. Three common mistakes, made by primary care practitioners and specialists alike, are described along with specific suggestions for a better approach. Most recommendations apply to those patients with more severe or disabling headaches, who perhaps are not responding to adequate care, but the fundamental principles can be

applied in some degree to every patient with migraine.

### **Mistake #1: Taking An Inadequate History**

Not talking to patients is a primary problem. Quickly focusing on a history of headache and prescribing or advising based on that symptomology alone is inadequate. What is needed is a full intake evaluation that questions, examines, and studies the complete patient, as well as the patient's complaint of headache.

Gathering a complete medical history requires time. Therefore, scheduling adequate time for a complete intake examination and follow-up visits is key. The first visit can be especially important in establishing a working alliance between the physician and patient. Having more time for building rapport provides an essential base for the type of chronic care necessary to treat migraine. As optimal treatment of depression requires a foundation of the physician-patient relationship, so does migraine require a partnership between care provider and patient.

A sustained initial contact also provides time for gathering clues about the patient's symptoms, coping mech-

anisms, and previous attempts to stop the pain. Impressions formed in this interview directly shape treatment choices. To get the most information out of patients while building trust, many physicians encourage patients to express the features of their headaches in their own words and without interruption. Checklists of questions, yes/no interviewing, and pain-severity rankings have their place, but an open, relaxed invitation to discussion often provides a more appropriate beginning.

More passive patients, of course, may need prompting. Highly verbal patients may require focusing. In all cases, the physician will likely need to backtrack to fill in the blanks in the history with direct questioning. However, encouraging the patient to talk is an excellent first step in long-term therapy. The types of details that must be clarified in the initial history are listed in Table 1, and the International Headache Society criteria for headache provide the standard for completeness.<sup>1</sup>

A critical part of this early information-gathering phase is recognition of more than one type of headache. Some patients may have five migraines a month but also daily background headaches; the everyday headaches may seem normal to them by now, but the physician needs to be aware of this ongoing condition. Or perhaps a patient presents with acute sinusitis on top of a pattern of migraine. Again, the complete history is key in recognizing the coexistence of more than one headache disorder in the same patient.

In addition to the core clinical history, the initial visit should offer insight into the patient's interpersonal relationships and ability to function. What is the patient's internal mechanism of dealing with the stress of illness? Is he or she functioning well at home, at work? How do friends, family, coworkers, and supervisors respond to the condition?

**Table 1.** Details Needed from History

<ul style="list-style-type: none"><li>■ The nature of the typical attack Including details on onset, pattern, frequency, duration, intensity, location, quality of pain, precipitating factors, aggravators, ameliorators</li><li>■ The number of types of headaches</li><li>■ Associated symptoms</li><li>■ Neurologic accompaniments</li><li>■ Prior consultations</li><li>■ Previous treatments</li><li>■ Past medical and surgical history</li><li>■ Family/hereditary history</li><li>■ Personal and social history</li><li>■ Systems review</li></ul>
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Answers will build a picture of the person with migraine and establish parameters for selecting the best treatment.

After the full medical history, a screening neurologic examination must follow. If any findings are questionable, the appropriate laboratory profiles or special neuroimaging tests must be ordered. The American Academy of Neurology has established practice parameters for utilization of computerized tomography (CT) scanning, magnetic resonance imaging (MRI), lumbar punctures, and electroencephalograms (EEGs); these parameters provide up-to-date advice on selection and use of neurologic diagnostic tests.<sup>2-4</sup> Summary guidelines based on these parameters are listed in Tables 2, 3, and 4. Patients need to understand that none of these tests confirm the diagnosis of migraine. They merely exclude secondary causes of headache. The working diagnosis comes from the history and is supported by the lack of physical findings and negative diagnostic testing (performed as indicated).

Finally, several open-ended questions asked during the initial examination can often lead to high-yield responses. These include:

- Is there anything else that you think I need to know?
- What concerns you the most?
- What do you believe is the matter with you?

Such questions have a tendency to uncover basic fears and unstated demands. Patients may fear a brain tumor. They may want an MRI. They may think their migraines are their own fault. Getting these beliefs into the open is the only way to deal with them honestly, to provide reassurance, and to establish a long-term partnership. This partnership opens the door to free communication, and provides practitioners with the leverage to discourage unnecessary treat-

ments or testing and to encourage compliance over the longterm.

**Mistake #2: Allowing the Patient to Overuse or Misuse Medication**

The abuse of headache medication can sabotage the best efforts to treat

**Table 2.** Guidelines for the Use of Lumbar Puncture

<ul style="list-style-type: none"> <li>■ First or worst headache ever experienced</li> <li>■ Rapid onset or “thunderclap” headache</li> <li>■ Headache with altered consciousness or fever and meningeal signs</li> <li>■ Chronic, intractable headache unresponsive to appropriate medical management</li> </ul> <p>Contraindications and Cautions:</p> <ul style="list-style-type: none"> <li>■ Increased intracranial pressure with a mass lesion or obstruction of the ventricular system</li> <li>■ Coagulation defects or anticoagulation therapy</li> <li>■ Complete spinal subarachnoid block</li> <li>■ Focal suppuration at the intended puncture site</li> </ul>
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**Table 3.** Guidelines for the Use of Neuroimaging

<ul style="list-style-type: none"> <li>■ An abnormal neurological examination             <ul style="list-style-type: none"> <li>Decreased alertness or cognition</li> <li>Focal findings</li> <li>Nuchal rigidity</li> </ul> </li> <li>■ Worst headache ever experienced—especially if it is of rapid onset</li> <li>■ The presence of accompanying neurologic symptoms that do not meet the criteria for migraine or other primary headache disorder</li> <li>■ A significant change in the pattern of established headache disorder</li> <li>■ No response to appropriate therapy</li> </ul>
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**Table 4.** Guidelines for the Use of EEG

<ul style="list-style-type: none"> <li>■ Headache and episodic loss (or alteration) of consciousness</li> <li>■ Headache and seizure disorder</li> <li>■ Atypical migrainous aura</li> </ul>
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patients with migraine. Even leaving aside cost issues, which can be considerable in misguided therapy, an uneducated and unsupervised patient taking acute medications inappropriately can lead to ineffective therapy and perhaps even refractoriness or tolerance—not to mention possible medical injury. Preventing a cycle of misuse, overuse, and refractoriness should be a goal in all cases. Guidelines for proper medication use are summarized in Table 5.

One of the first steps toward this goal is establishing usage limits. In the case of abortive agents—or “migraine-specific” therapies—a limit of no more than 6 to 8 days per month should be observed. Similarly, symptomatic or “pain” medication should not exceed 8 days of use per month. This includes analgesics of any kind (eg, over-the-counter (OTC) simple or combination analgesics, nonsteroidal anti-inflammatory drugs (NSAIDs), and prescription agents). The message for patients is that if they require more than these amounts, their current therapy is not adequate. Preventive approaches need to be considered.

Patients must also be educated in the proper timing of “instant relief” medication. Many patients misuse acute therapies in anticipation of pain or out of fear that mild pain will wors-

en. Fortunately, we now have excellent therapeutic options that work when the headache is at or near climax. If patients are using currently available medications but still following the guidelines for older therapies—for example, taking medications at the first sign of headache—they may end up overusing the medication, and eventually diminish its effectiveness. The message for patients should be clear: if you take too much of this medication, tolerance, refractoriness, or rebound may result. The worst possible consequence—serious medical injury—is rare, but is a possibility about which patients should be made aware.

For patients who are already ineffectively overusing one or more of the acute therapies, education is necessary to convince them that the offending drug or drugs must be stopped in order to interrupt the cycle of rebound and to gain control over their headaches. It is important to tell patients that withdrawal symptoms may occur and that there will likely be delayed headache improvement after stopping misused medication. These patients typically require some support in order to get through this transitional period. Otherwise, they are at high risk for a relapse and resumption of their prior maladaptive behavior.

At some point in the management of recurring headache, patients and physicians need to consider preventive therapy. Prophylactic therapy should be offered to patients with two or three incapacitating headaches per month, or one prolonged severe attack. Preventive therapy is indicated for patients who do not respond to acute therapy, who have significant side effects to acute therapy, or who are unable to cope with the uncertainty, pain, and disability of migraine. Patients for whom abortive therapy is contraindicated can profit from preventive therapy.

**Table 5.** Medication Messages in Migraine

Analgesics and abortive agents: Know the usage limits
Decongestants: Don't use
Corticosteroids: Use cautiously, if at all
Instant relief medication:
■ Know how to time the dose to the pain
■ Know the potential problems of improper timing or overuse
Preventive agents: Use when abortive therapy has failed

Whichever treatment course is pursued, patient education remains the key to avoiding most medication problems. Ideally, education builds on the patient-physician-nurse partnership established in the initial consultation. Patients can, for example, be encouraged to record attack characteristics and possible trigger factors in conjunction with daily medication use. This type of diary can provide a wealth of accurate information not only about potential medication overuse or underuse, but also about lifestyle factors, especially sleep, diet, and stress, that may be contributing to migraine attacks.

The frequency of follow-up exams to monitor treatment will vary from patient to patient. In many cases, a phone call from a physician or nurse will be adequate. In all communications, a reassuring and nonjudgmental tone will help retain the trust of patients, although a certain firmness may be required at times.

It is becoming more common for patients to come to their practitioners requesting a specific drug for acute therapy of migraine. Although it takes time to respond to each request and to explain why the requested treatment is or is not appropriate, it is time well spent. Physicians should use this opportunity to educate the patient and direct the treatment plan in a medically sound way. Each patient deserves some option for acute therapy (within established limits), and some require preventive therapy as well. In any case, maintaining an open and honest patient-physician relationship will produce the best therapeutic results.

**Mistake #3: Failing to Prepare the Patient for the Long Term**

Because migraine is a chronic condition, an up-front investment in history gathering and treatment education can yield a variety of long-term benefits. In fact, failing to prepare the

patient for a long course of therapeutic ups and downs is a common prelude to treatment misadventures or failure. Whether due to lack of time for proper counseling, or an overly optimistic view of drug efficacy, the uninformed or misinformed migraine patient is all too common in today's specialty headache clinics.

As previously mentioned, patients should be fully informed about the potential causes of headaches and about the presence or (more likely) absence of any serious underlying illness. A full description of currently available treatment options, including negatives and positives, is also necessary. The reassurance that their headaches are not life threatening and that treatment options are plentiful is a critical first step in education.

Within this positive framework, education should continue to establish realistic expectations. The overall goals of treatment (Table 6) should be clarified, emphasizing that the treatment goal is control, not cure. Patients need to understand that time is usually required for real improvement. Setbacks in treatment are common. Adjustments in the therapeutic regimen may be required.

Any unrealistic hopes for an instant cure need to be addressed up front. Most patients will respond quite well to the initial therapy but, inevitably, a bad time will follow. If patients are not prepared for this setback, they may feel personally at fault or they may direct dissatisfaction at

**Table 6.** Therapeutic Goals in Migraine: Control, Not Cure

<ul style="list-style-type: none"> <li>■ Reduce the frequency, duration, and severity of attacks</li> <li>■ Restore normal lifestyle</li> <li>■ Allow patient to control headaches, not vice versa</li> </ul>
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the practitioner or health plan. The patient with realistic expectations, on the other hand, will be ready to work with the practitioner on revising the treatment plan as needed over what often becomes a decade-long trajectory of disease.

What will these treatment revisions look like? In some cases, auto-regulatory techniques may be helpful. For example, many patients may benefit from something as simple as a book or audiotape on biofeedback. A series of sessions with a specialist or biofeedback technician is not always required. In others cases, the new treatment approach may necessitate a trial with a different drug regimen. A change in the form of administration often improves results. For example, medication delivered through a nasal spray can be effective when oral tablets have failed in the migraine patient as indicated by nausea, vomiting, or gastroparesis. All patients, over the length of their illness, should be encouraged to fine-tune their awareness to potential triggers and modifiers.

Whatever the specific treatment course, the connection of patient with practitioner must remain constant. Headaches are among the most disabling, yet most subjective and there-

fore misunderstood of all conditions. Without a clinician partner to demonstrate concern and provide guidance, the migraine patient is left alone and in pain. With so many effective treatments now available, both primary care physicians and specialists should be prepared to lead migraine patients on a long-term course of therapy that significantly reduces the burden of disease.

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