EDITORIAL

Migraine and Chronic Daily Headache - We Could be Doing Better

Can. J. Neurol. Sci. 2008; 35: 2-3

In 1983, Ninan T. Mathew, writing in the Headache issue of the first volume of Neurologic Clinics, made the following remarks:

Over the past few years, a few well-organized headache clinics have been established in various parts of the world where the approach to the treatment of chronic headache patients is different from that of a busy physician whose interests are not particularly directed to headache. The basic purpose of the headache clinic is to provide a comprehensive evaluation of the headache, the person suffering from headache, and his or her environment; to make an adequate diagnosis, to initiate prophylactic therapy (often multimodality), and to provide continuity of care.[1]

In the same article, Mathew points out that chronic headaches should be regarded as:

…a major health problem because of the loss of productivity, increased health-care dependency, billions of dollars spent on ineffective and often harmful over-the-counter as well as prescription medications, habituation to medications, and secondary problems in family, social, and sex life. Frequent headaches interfere with the patient's ability to function and enjoy life.

In the almost quarter century since these remarks were written, little progress seems to have been made in the effort to improve the lives of patients with chronic headache. Many patients with chronic daily headache never consult a physician. Others have given up on the medical profession because their physicians seem unable to help them. This is not too surprising, given the very limited expenditure of research funds on the problem of migraine and chronic headache. Shapiro and Goadsby, writing in Cephalalgia in September of this year, comment on the fact that:

…migraine is the least publicly funded of all neurological illnesses relative to its economic impact" and "…anxiety and affective disorders, two of the most prevalent categories of disorders comorbid with migraine, rank nearly as low as migraine in European public research funding priorities relative to economic impact. The cumulative effect of these funding decisions is to deny migraineurs the promise of research developments to change the courses of their illnesses.

The lack of public research support for migraine is not limited to European grant-giving agencies. The problem is equally profound in the USA.[2]

We can echo them and say that Canada is no different. What is surprising is that remains the case despite the fact that the World Health Organization ranks severe migraine attacks as being as disabling as dementia, quadriplegia and active psychosis[3] and despite the fact that headache has been found to cause 42 percent of the loss of productive time due to pain conditions in the United States, at an estimated annual cost of US$ 25.7 billion.[4]

It is widely acknowledged that in chronic daily headache (CDH):

Behavioral, psychological, and disabilitiy aspects… need to be considered when treating patients with this form of headache. A multimodality approach is essential for satisfactory results, and a combination of pharmacologic and behavioral interventions is necessary.[5]

Nevertheless, most patients with this condition, if they receive their care from a physician at all, do so from physicians who are busy and who by training and temperament may be ill-equipped to deal with their patients who suffer from chronic daily headache. Even those of us with an interest in headache, tend to practise in clinical settings in which resources are limited, especially consultative services from our behavioural colleagues — psychiatrists, psychologists and social workers. Specialized, multi-disciplinary headache clinics in Canada are not available to most patients with headache. The Canadian Pain Society, as of May 2006, listed over 100 pain clinics on their website.[6] The majority of these are not specialized in the treatment of headache in a multidisciplinary fashion and most are in larger urban centres.

In this issue of the Journal, Sauro and Becker report on their experience at CHAMP (The Calgary Headache Assessment and Management Program), with a multidisciplinary approach to headache treatment.[7] This program uses five "pillars": an education session, a lifestyle assessment, a self-management workshop, a nursing assessment and a physician assessment to better treat headache patients. Migraine (with and without aura), medication-overuse headache, and chronic migraine accounted for over 90 percent of their clients. Almost half (47 percent) met the criteria for transformed migraine. Patient satisfaction with the program was high. After completing the Self-Management workshop, the number of headache days per month was reduced from a mean of 18 days to 12 days and headache disability was also reduced as was headache intensity and suffering. Magnusson et al have shown previously that a pain-centre based multi-disciplinary headache program is more effective than an out-patient, physician-based specialty headache clinic.[8] The

CHAMP multidisciplinary program, despite being less intensive, has proven itself successful in this population of patients with headaches that tend to be very treatment resistive.

Despite the accumulating evidence of the success of this approach, widespread adoption of such programs is likely to remain problematic in the present healthcare climate in Canada for a number of reasons. The "gains" achieved by such programs do not translate into savings for the organizations that have the dollars to support such efforts. While these patients may consume Emergency Department resources, they do not occupy beds and therefore gains in function or reduction in suffering are unlikely to be seen as "wins" for the hospital sector and therefore unlikely to be ranked highly in competitions for scarce hospital resources.

What is needed is a concerted effort by provincial ministries of health to recognize the serious burden that chronic headache has on the population and to fund studies that will answer whether this type of program is cost-effective, and show which parts of the program are most effective and whether parts of the program could be delivered in innovative ways (e.g. telehealth) to ensure that individuals in more remote areas of the province can also partake of the benefits of such programs.

Sauro and Becker's[7] study should be a clarion call to ministers of health everywhere that patients with difficult headache problems are currently not well served by the health care system and indicate to them that we could be doing better than we are—much better.

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