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Best Practices for Patients With Chronic Migraine: Burden, Diagnosis, and Management in Primary Care

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Abstract

Headache and migraine are common medical complaints among patients visiting primary care physicians (PCPs). A number of these patients may have chronic migraine, which is more difficult to diagnose and manage than many other headache disorders. Identification of those at risk, correct diagnosis, and establishment of a comprehensive management plan for patients with chronic migraine will require a joint effort between the PCP and the headache specialist. Together, the PCP and headache specialist will need to assess the patient for modifiable exacerbating factors and comorbidities while managing prophylactic and as-needed therapies. Herein, we provide a review of chronic migraine for the PCP and describe tools for improving patient care.

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Headache is a common medical complaint among patients seeing their primary care physicians (PCPs), accounting for 1 in 10 general practitioner consultations.[1] The prevalence of migraine in the general population is approximately 6% in men and 15% in women, peaking at the age of 40 years.[2] Diagnostic studies have shown that up to 75% of patients who visit a PCP complaining of headache may have migraine[2] and an estimated 1% to 5% of these patients will have chronic migraine.[3]

Patients with headache will often present to their PCPs before consulting a specialist. For this reason, PCPs are essential for the identification of this patient population and appropriate referral to neurologists or headache specialists. Treatment models for chronic migraine should therefore include the PCP for suspected diagnosis and appropriate referral, as well as for managing patient care between specialist appointments.

Patients with suspected chronic migraine should be referred to a neurologist or headache specialist, not only to confirm the diagnosis but also to initiate a treatment plan, including both as-needed and prophylactic treatments. Prophylactic treatments reduce attack frequency and duration and often improve the response to as-needed medications. Although evidence-based prophylactic treatment options are limited for chronic migraine, controlled trials for topiramate and onabotulinumtoxinA exist, and prophylactic medications used for episodic migraine are often used for the preventive treatment of chronic migraine. The objective of this review of chronic migraine and the available treatment options is to guide the PCP to better identify patients with chronic migraine, refer appropriately to headache specialists, recognize and address exacerbating medical and psychiatric comorbidities, and manage care in between specialist appointments.

EPIDEMIOLOGY AND BURDEN OF CHRONIC MIGRAINE

Migraine is a common incapacitating disorder characterized by severe headache and disabling associated features, including nausea, vomiting, photophobia, and phonophobia, according to the International Classification of Headache Disorders, third edition.[4] Migraine is associated with substantial disability, low health-related quality of life (HRQoL), and high economic burden.[5] Chronic migraine, as defined by the International Classification of Headache Disorders, third edition, is diagnosed when a patient experiences 15 or more headaches/mo for 3 or more months, in which 8 or more headaches/mo meet criteria for migraine with and without aura or respond to migraine-specific treatment.[4] Chronic migraine has an even greater

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effect on disability and economic burden than has episodic migraine (<15 headaches/mo), as found by several large-scale epidemiology studies. The International Burden of Migraine Study, for example, found that patients with chronic migraine had lower HRQoL than did those with episodic migraine.[5] Persons with chronic migraine are also more likely to experience severe disability, such as an inability to work, attend social functions, and perform routine chores,[5] and have markedly more severe disability than do those with episodic migraine.[5]

Identification of patients with chronic migraine is the first step toward treatment, but as a recent study found, proper diagnosis is often elusive: only 20% of patients who fulfill the criteria for chronic migraine are diagnosed with the disorder.[6] Improving the diagnosis of chronic migraine, eliminating/minimizing exacerbating factors, and optimizing treatment can substantially reduce the personal and global burden.[7,8]

DIAGNOSIS OF CHRONIC MIGRAINE

Patients presenting with a history of headache should first be evaluated for a secondary cause of headache, which may be ruled out through careful history taking and examination.[9] If no "red flags" for a secondary headache are identified, patients with chronic headache should be assessed for a primary headache disorder, which can include chronic tension—type headache, new daily persistent headache, hemicrania continua, and chronic migraine.[4,9] The differential diagnosis and recognition of chronic migraine is usually the role of the PCP.

A simplified diagnosis of chronic migraine has been proposed that includes a patient experiencing 15 or more headaches/mo, each at least 4 hours in duration, with headaches on 8 or more days each month associated with migraine features, with or without medication overuse.[4,10] Even with these guidelines, it may be difficult to pinpoint a diagnosis, because patients may not be able to report the number of headaches they have each month with any degree of accuracy without a record or "headache diary." It is therefore useful to ask patients, "Do you feel like you have a headache of some type on 15 or more days per month?"[10] In addition, patients will usually report their "severe headache days" but may fail to mention their milder or more moderate headache days, so it is important to ask, "How many days each month on average are you completely free from any type of headache?" Because many patients use over-the-counter analgesics in addition to prescription medications, it is important to identify how often a patient uses an as-needed medication because overuse may be a significant exacerbating factor and may lead to systemic toxicity. Therefore, an important question for the patient is "How many days per month on average over the last 3 months do you take a medication to treat a headache?"

Additional information that may facilitate a diagnosis and guide clinical decision making includes risk factors for chronification from episodic to chronic migraine (as identified in population- and clinic-based studies), which include obesity (especially when comorbid with depression or anxiety), a history of frequent headache (>1 headache/wk), caffeine consumption, and overuse of as-needed headache medications (>10 d/mo), including analgesics, ergots, and triptans.[9,11]

Once a patient with chronic migraine is identified, a treatment plan may be developed. This includes referral of the patient to a neurologist or headache specialist as well as careful follow-up with the patient in the clinic. Although these specialists will be key to managing the patients' headache condition, PCPs will still be critical in the management of modifiable risk factors and comorbidities as well as monitoring patients through the use of validated questionnaires and headache diaries.

TREATMENT PLAN FOR CHRONIC MIGRAINE

Every chronic migraine treatment plan should include both prophylactic treatment of reduction of headache days and severity and as-needed treatment of exacerbations. Prophylactic treatments should be initiated in patients with chronic migraine.[12] Evidence-based prophylactic medications for episodic migraine are often used for chronic migraine. These agents include topiramate,[13,14] gabapentin,[15] tizanidine,[16] fluoxetine,[17] amitriptyline,[18] and valproate.[19,20] It is important to note that of these agents commonly used for treating episodic migraine, only topiramate has been shown to be efficacious in randomized, placebo-controlled clinical trials in patients with chronic migraine.[13,14]