

Headaches: Diagnosis and management of headaches in young people and adults

Stakeholder workshop

7th July 2010

NICE, MidCity Place, 71 High Holborn, London, WC1V 6NA

Summary notes

The stakeholder scoping workshop is held in addition to the formal consultation on the scope which is taking place from the 12th August until the 9th September 2010.

The objectives of the scoping workshop were to:

- obtain feedback on the specified population and key clinical issues included in the first draft of the scope
- seek views on the composition of the Guideline Development Group (GDG)
- encourage applications for GDG membership

The scoping group (Technical Team, NICE and GDG Chair) presented a summary of the guideline development process, the role and importance of patient representatives, the process for GDG recruitment and proposed constituency for this group, and the scope. The stakeholders were then divided into three groups which included a facilitator and a scribe and each group had a structured discussion based around pre-defined questions relating to the draft scope. Comments received from each discussion group have been combined and summarised below.

No.	Scope section	Question & comments
1.	4.1 Population a) Young people 12 years and older adults b) Young girls and women of reproductive age to include treatment during pregnancy, management of menstrual related migraine and choice of	Is the population appropriate? Do you think there is a need for any other particular subgroups (other than young girls and women of reproductive age)? Would it be better to include children in this guideline, or do a separate guideline for children?

27th July 2010

	contraception	
		<p>Population appropriate – useful to include the transition from adolescent to adult. Would prefer to define age as ‘puberty’ rather than specifying 12 years as an age cut-off as many children start developing migraines at puberty, which can often be age 9 or 10. Then can dove-tail on to children’s guideline.</p> <p>Reasons to include those age 12+:</p> <ul style="list-style-type: none"> • Presentation and treatment similar above 12 • Young people also beginning to take responsibility for own treatment • Young people are seen by both GPs and paediatricians • More drug licenses in those over 12 compared to younger children • Young people over 12 are able to give better description of symptoms than younger children <p>Older people, over 80 years old are likely to have a different spectrum of diagnosis than young people. Headaches are unlikely to develop after 70 years.</p> <p>Setting was queried: possibly should include pharmacies and schools.</p>
2.	4.3 Clinical management GENERAL	<p>Is the approach for this scope appropriate? <i>The intention is for this guideline to focus on headaches that can be diagnosed and managed in non-specialist healthcare settings. Is there agreement that this is what’s needed?</i></p>
		<p>Agreed as appropriate, although A&E setting should also be considered as they see a lot of people presenting with headaches and need some guidance on how to rule out urgent cases. Acute onset headache should be mentioned.</p>
3.	<p>Clinical Management 4.3.1 Key clinical issues a) Diagnosis and investigations - Diagnosis of Primary Headaches – Migraine with or without aura, chronic migraine, tension-type headache, chronic daily headache, cluster headache - Diagnosis of following Secondary Headaches – medication overuse headache, giant cell arteritis, cerviogenic</p>	<p>Are there any specific common headaches that the group believe have not been included? <i>The guideline will be limited to the diagnosis of the headaches stated (Primary and Secondary).</i></p>

	<p>headache - Rule out other secondary headaches</p>	
		<p>Some discussion on the use of the term 'chronic daily headache' - not meaningful to the people who will use the guidelines. Use as an umbrella term (representing headaches that occur for 15 days or more per month) and re-word as 'Diagnosis of chronic daily headache, to include subgroups: chronic migraine, tension type headache... etc.'</p> <p>Acute onset headache should be considered separately as it can help rule out those with a sinister pathology.</p> <p>Need to ensure that people with more than one headache type are covered – mixed type headache. Also include unclassifiable headache – probably accounts for about 10% of headaches and patients do benefit from lifestyle/diaries/simple treatments etc.</p> <p>Include hemicranias – easy to treat and diagnose.</p> <p>Cluster headache suggested to be too narrow a description – a more complete description is available in the literature (cluster headache and other trigeminal autonomic cephalalgias).</p> <p>There is a need for doctors to know which patients need scans straight away and which to refer on as well as thinking beyond scanning.</p> <p>Should be more specific for other secondary headaches. Suggest re-word as 'Rule out other secondary headaches that require urgent acute action'.</p> <p>It was suggested that as giant cell arteritis requires urgent acute action it could be removed from the list of secondary headaches that would be diagnosed.</p> <p>Head and neck headache should be included in secondary headaches.</p> <p>Some suggestion that secondary headache list should only include head and neck headache and medication overuse headache.</p> <p>Some discussion about not covering the management of cervicogenic headache. Agreed as OK as long as management was then intended to be by a specialist.</p> <p>Sinusitis often misdiagnosed as migraine, therefore there was a query whether it should be included in diagnosis.</p> <p>Query whether patients with chronic headache should be screened for depression.</p> <p>Possibly need to be more specific about assessment – query whether diaries should be included.</p> <p>Imaging needs to be included under diagnosis as well as in management.</p> <p>Rule out toxic headaches- alcohol/carbon monoxide.</p>

4.	<p>Clinical management 4.3.1 Key clinical issues b) Acute pharmacological treatment of migraine, tension-type headache, chronic daily headache and cluster headache <i>with aspirin, paracetamol, NSAIDs, triptans, opioid analgesia or verapamil</i> c) Prophylactic drug treatment of migraine, tension-type headache, chronic daily headache <i>with beta blockers, tricyclic antidepressants, SSRIs, anti-epileptic drugs, pizotifen, cyproheptadine, methysergide and botulinum toxin</i></p>	<p>Is the list of pharmacological treatments stated appropriate? If you could remove one, what would it be?</p>
		<p>Some additional treatments were suggested: Acute treatment: anti-emetics – also suggest to include oxygen here. Prophylactic treatment: steroids, lithium, calcium channel blockers (flunarazine & verapamil), ACE inhibitors, neuromodulators, antidepressants, clonidine, magnesium. Verapamil should be included within prophylactic treatment instead of acute. Important issues raised regarding dose/timing and combination of prophylactics as well as singly. Whether or not treatment of depression should be included was queried. Oxygen should be included here rather than non-pharmacological. Note: may be issues regarding licensing, at both ends of age spectrum e.g. triptans not licensed in those over 65 years. Note: new migraine specific treatment GPANTS likely to be applying licence 2012/13.</p>
5.	<p>4.3.1 e Non-pharmacological management of primary headache - Oxygen – Imaging – Psychological therapies (CBT) – Manual therapies – Acupuncture</p>	<p>Is the list of non-pharmacological managements appropriate? If you could remove one, what would it be?</p>
		<p>Relaxation should be added as a separate topic.</p>

		<p>Widen psychological therapies, or perhaps do not specify (just state 'psychological therapies'). Biofeedback is also used.</p> <p>Complementary therapies should either be included, or at least acknowledged as another possible treatment that patients frequently use (including. vitamin B12, coenzyme Q10, magnesium, riboflavin).</p> <p>Pain behaviour, eye movement rapid sensitivity.</p> <p>Some felt imaging should be included separately rather than a treatment strategy.</p> <p>Lifestyle factors (e.g. diet, alcohol, sleep, intolerance, allergy, exercise and obesity management).</p> <p>Education & information.</p>
6.	4.3 Clinical management GENERAL	<p>What are the top two issues i.e. what will most improve patient and carer outcomes?</p> <p><i>Try to frame the answer in a PICO format i.e. what is the population, intervention and comparison?</i></p>
		<p>Diagnosis is a key issue, particularly of medication overuse headache and better defining migraine and differential diagnosis (including toxic headache).</p> <p>Better management to reduce inappropriate referrals.</p> <p>Increasing recognition of headache as an important condition to manage after secondary headaches have been ruled out.</p>
7.	4.3 Clinical Management GENERAL	<p>Are there any critical clinical issues that have been missed from the scope that will make a difference to patient care?</p>
		<p>Some query about ruling out management of cervicogenic headache (see question 3).</p> <p>Include management of cervicogenic headache.</p> <p>Should also include headache diaries, to look for headaches triggers (e.g. foods) which can prevent the need for further investigation / treatment.</p> <p>The guideline should consider treatment duration. 3-6 months generally considered as the minimum, is there evidence for this?</p> <p>Need information/education section.</p> <p>Something about reviewing chronic patient- often misdiagnosed e.g. bad headache = migraine.</p> <p>Possibly something about headache being common and often seen with a variety of disorders e.g. constipation.</p> <p>Co-morbidities: chronic stress, anxiety, fatigue.</p> <p>Treatment management – think about combination of drugs.</p>

8.	4.3 Clinical Management GENERAL	Have we included any areas that are irrelevant and could be deleted?
		None raised.
9.	4.3 Clinical Management GENERAL	Are there areas of diverse practice, or uncertainty that require address?
		None discussed
10.	4.3 Clinical Management GENERAL	Are there areas of poor/unsafe practice that require address?
		None discussed
11.	4.4 Main outcomes a) Freedom from pain and pain free over 24 hours following acute treatment b) Changes in patient-reported headache frequency and intensity e.g. headache days in the last month c) Measures of headache frequency, intensity and effect on life e.g. Headache Impact Test (HIT) migraine disability assessment test d) Functional health status and Health related quality of life e.g. SF-36 health survey, EuroQoL e) Over-the-counter medication usage f) Medication overuse headache g) Resource use – GP consultation, investigations, referral to secondary care	Please prioritise the specified list of outcomes. A higher priority would indicate that a recommendation on this topic would make a bigger difference to patient outcomes. Are there any outcomes not listed that should be of higher priority than those already included? If so, which one would you remove?
		Agreed that the migraine specific questionnaires are very useful and commonly used in clinical trials e.g. the migraine disability assessment test.

		<p>It is more likely that studies will report headache specific quality of life tests rather than general outcomes such as EuroQol etc.</p> <p>Point 'a' should be 'Time to freedom from pain and pain free over...'</p> <p>Points 'b' & 'c' can be combined as the questionnaires include patient report of headache frequency etc.</p> <p>Point 'g' should also include A&E attendance.</p> <p>50% responder rate mentioned (50% pain relief).</p> <p>Additional outcomes suggested:</p> <p>Morbidity in adolescents due to headache (Also think about self-administration of drugs for adolescents)</p> <p>School days and workdays lost due to headache</p> <p>Health impact in different types of headaches</p>
12.	4.5 Economic aspects	<p>Which clinical area is likely to have important economic implications, i.e.:</p> <ul style="list-style-type: none"> • Involve a fundamental change in current medical practice; • Important implementation considerations; • High intervention cost / high resource use involved. <p>Are there any areas that are known to be non cost effective – interventions that are not of benefit to patients?</p> <p>Are there any new practices that might save money compared to existing practice?</p>
		<p>Diagnosis is a critical economic issue.</p> <p>Opioids expensive.</p> <p>Better diagnosis of medication overuse headache.</p> <p>Scan overuse.</p> <p>The high level of the placebo effect in headache treatment should be considered – it may be hard to get meaningful QALYs.</p>
13.		Does the current scope look realistic in timeframe?
		Not discussed
14.	GDG Constituency	Do we have the right expertise on the group?

	<ul style="list-style-type: none"> • Neurologist x 2 • Paediatrician or paediatric neurologist with an interest in headache in young people • GP with a specialist interest in headache • GP • Pharmacist – Hospital or Community • Doctor/nurse practitioner working in emergency service such as A/E or out of hours service • Pain specialist • Patient members x 2 • Co-opt - Psychologist, Manual therapist, acupuncturist 	
		<p>Neurologists should be specified as 1 with an interest in headache and 1 general neurologist. Emergency services should be 'Doctor working in emergency medicine or acute physician'. No need for a pain specialist (if we are ruling out management of secondary headaches). Headache speciality nurse should be included. An adolescent patient member should be included. Manual therapist should be considered as a full GDG member rather than co-opt.</p>
15.		Were there any other issues raised during the discussions that should be noted?
		<p>In wording of clinical issues that will not be covered, suggest re-wording to 'Management of secondary headache other than medication overuse headache after ruling out those that require urgent acute action'.</p> <p>There was a question on whether prognostic factors will be considered.</p> <p>It was suggested that when looking at treatment outcomes a minimum duration for treatment should be 3 to 6 months. Anything less would not be relevant.</p> <p>The most useful thing to have would be an algorithm to follow.</p>

The meeting was closed by a brief summary of the points discussed at each table. Attendees were informed of the scope consultation dates and process and that GDG recruitment would happen simultaneously. Further comments on the scope and applications for GDG membership were encouraged.