Dawn A. Marcus
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Discussing Migraine with Your Patients

A Common Sense Guide for Clinicians

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Foreword

Migraine is a common and disabling neurologic condition. One billion people on the planet or someone in one of every four households lives with migraine. Over half of people with migraine have never been diagnosed or treated. Those who do seek care often present to primary care professionals, although migraine may also be managed by neurologists or headache expert physicians. Therefore, primary care professionals and neurologists alike need to have the knowledge, skills, and tools necessary to successfully manage patients with migraine and help them achieve the best outcomes possible. The title of this book references the importance of effective communication. There are no lab tests to diagnose migraine. It is a diagnosis that happens through effective history taking and conversation. For the most part, migraine attacks primarily occur outside of the office or hospital. Healthcare professionals may diagnose in the office, but treatments will generally be administered by the patient himself or herself. While the patient is in the office, the healthcare professional and patient should work as a team to develop a mutually agreed upon treatment plan and discuss actions that the patient will need to follow both in the case of a migraine attack and also on a daily basis to optimize health and reduce chances of attacks. The healthcare professional is a coach who does his or her best to equip the player with everything that he or she needs during the big game, gives him or her the knowledge necessary, practices the skills and instills motivation, but the patient will ultimately face the migraine attack alone and needs to rely on the tools, skills, and knowledge imparted by the healthcare professional.

Successful adherence to any treatment plan can be challenging. A medication or treatment that is taken incorrectly or not at all has little chance of success in managing a condition. Research shows that the majority of people with migraine are not adherent with prescribed treatments for a variety of reasons. Many patients will require daily preventive medication, which can be challenging for patients to accept. It can be even more difficult to motivate patients to engage in the important behavioral, psychological, or physical therapies or make the necessary lifestyle changes, which may include exercising, weight loss, smoking cessation, getting adequate sleep, or modifying diet. This book offers strategies for enhancing adherence and motivating patients to be active participants in their own treatment success.

Michael Ready, M.D., and Dawn Marcus, M.D., are headache expert physicians with decades of clinical experience as well as scientific publications and awards to their credit. Dr. Ready is a well-respected headache expert who has received awards from the National Headache Foundation highlighting his contributions to the field of headache. Dr. Marcus was an excellent clinician who also authored nearly 20 books for both healthcare professionals and patients with migraine, fibromyalgia, cancer, and other chronic illnesses. She had a special way of connecting with readers, patients, and colleagues and was always interested to interact, hear opinions, and answer questions. She did this while maintaining an active clinical practice, being a devoted mother and wife, raising therapy dogs, and actively participating in philanthropies such as the Canine Support Team's Pawz for Wounded Veterans program. Tragically, Dawn Marcus passed away in 2013, leaving behind a legacy of family, friends, devoted patients, and loyal readers. Dr. Marcus and Dr. Ready started this book before her passing, and it is a gift to the healthcare professionals and people with migraine alike that he has shepherded it through to publication. This is among Dr. Marcus' final books, making the wisdom that it contains especially valuable. It also introduces Dr. Michael Ready as a new author and fresh voice, giving a platform for his trademark wit and warmth to be shared with readers near and far.

Together, Dr. Marcus and Dr. Ready have written this valuable book to support healthcare professionals in providing the best possible care for their patients with migraine. *Discussing Migraine with Your Patients*: *A Common Sense Guide for Clinician* combines the wisdom of their clinical expertise with cutting-edge science and helpful clinical pearls. This book reviews migraine treatment according to empirical data, FDA approval, and consensus-based guidelines. Treatments range from acute and preventive pharmacotherapy, medical interventions and devices, behavioral and psychological nonpharmacologic therapies, education, trigger management, healthy lifestyle practices, stress management, nutraceuticals, and alternative medicine offerings. Patients and providers alike can easily become overwhelmed with the range of options available and interpreting the data available on treatments. This book synthesizes the scientific literature, making it readily accessible. However, this book goes beyond discussion of treatment, as that is only the tip of the iceberg in successful migraine management. The book reviews genetics and pathophysiology, symptoms and comorbidities, and essential clinical skills such as effective communication, enhancing patient self-efficacy, improving adherence and motivation, and other tools useful in achieving the best possible outcomes with patients. It contains useful handouts and questionnaires that Drs. Ready and Marcus use in their own practices. This book also tackles tough questions like how to respond when a patient asks, "Why did this happen to me?", "Will this ever end?", and "Will I ever get better?" combining scientific data with caring and compassion. The book closes with the chapter "What to Do When Nothing Is Working," which reviews a range of valuable suggestions and advice.

Healthcare professionals who manage patients with migraine will both enjoy and benefit from the information, advice, and patient handouts contained within this book. Managing patients with migraine on one's own can feel challenging and

isolating at times. *Discussing Migraine with Your Patients*: *A Common Sense Guide for Clinician* offers a range of suggestions on how to engage in successful communication, improve adherence, and enhance motivation for the active and successful management of migraine. The wisdom, wit, and warmth contained within this book will make you feel like you are discussing patient care over a hot cup of coffee with a trusted colleague.

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Preface

According to a report in the *Annals of Family Medicine*, the average primary care appointment lasts 10.7 min of face-to-face patient time.[1] Adding in time spent reviewing patient materials outside of the examination room boosted that total to an average of 13.3 min per patient. Somehow, you're supposed to use that time to review medical history, understand current headache symptoms, do an examination, prescribe treatment, and explain all about migraines to your patients. This can be a recipe for misunderstandings and frustration.

Sections in each chapter begin with an up-to-date synthesis of the latest research on each topic, providing the clinician with details of pertinent information as it applies to clinical practice. The remainder of each chapter includes a translation of that research into clinical practice, including practical examples and patient educational materials. These materials can be reproduced to supplement messages provided during typical clinic visits and enhance patient understanding and, hopefully, compliance with treatment recommendations. This material is designed to help engage the patient as an active treatment partner and ensure patients and their doctors are on the same page for treatment plans and expectations.

The chapter, "What to Try When Nothing's Working," will help with those patients we've all had who seem to have tried everything without success. Remembering that "common things happen commonly" and that commonly most people get better, this chapter explores refractory treatment options for numerous migraine perpetuating factors, uncommonly used pharmacological options, and multiple behavioral interventions for the patient that has "tried everything." This chapter also includes step-by-step instructions for office-based procedures, with complementary videos available at http://link.springer.com/book/10.1007/978-1-4939-6484-0.

Discussing Migraine with Your Patients: *A Common Sense Guide for Clinicians* provides a practical approach to headache management, using tried-and-true explanations and techniques that are easy to understand and resonate with patients with difficult-to-treat migraine. This book presents messages that successfully resonate with patients and the science behind those messages so the clinician can become an educated and effective salesman for delivering migraine care that really works.

[1] Gottschalk A, Flocke SA. Time spent in face-to-face patient care and work outside the examination room. Ann Fam Med. 2005;3:488–93.

That was the introduction as conceived by Dr. Dawn Marcus when she pitched this book. I only wish that she was here to see it finished.

I have long thought that communication's principal purpose is to change a behavior. I have especially found this to be true in migraine. All too often I see patients getting "hung up" on why they hurt, failing to accept migraine as a "good enough" explanation for their pain. Patients will continue to ask when their next CT or MRI will be ordered. This failure to understand and accept migraine as a "necessary and sufficient" explanation is what keeps people mired in inaction. Effective communication allows people to understand how they got there and what is keeping them there, thereby allowing them to see their way out.

Unfortunately, we're sent to medical school and often we forget how to speak English. We retreat to the comfort of medical jargon and abbreviations, which is challenging for most people to understand. This is even more of a problem in migraine, as this condition disproportionally affects the lesser educated and lower socio-economical classes. Because of this I had developed many stories and sayings to help patients understand their condition so they can act on that knowledge.

Putting these sayings on paper was Dawn's idea. Over the years she had been a tremendous resource for my headache practice and even more she became a friend. While we were visiting at a pain meeting, I started sharing with her several of the sayings and stories included in this book and she became very excited. She exclaimed "Michael, we have to write a book together!" Having never been an author or coauthor before, I was a little skeptical. Dawn reassured me (as she was a writing machine) that if I gave her the sayings, she'd find the science and I'll be damned, she did.

Once we started, the writing proceeded at a rapid pace. I became amazed at what she was able to do with my ideas. Then one evening, while I was seeing my last patient, I received an email with Dawn's name in the subject line. It told me about Dawn's heart attack and admission to hospice care. My first thought was this has got to be wrong. I had just gotten an email from her about some medication charts she wanted me to assemble. Returning my focus back to my patient I noticed she had a worn copy of Dawn's *The Woman's Migraine Toolkit* on her lap. At the time I might not have wanted to hear it, but that was likely Dawn's way of telling me that she, too, was surprised with what had happened but that wasn't important now. "Michael, you have a patient in front of you who needs your help and besides you still owe me those charts!"

I have been blessed with so many colleagues who have opened their practices, shared their knowledge, and encouraged me. The fellowship in this community runs deep. In particular, I would like to thank Drs. Roger Cady, Dawn Buse, and Elizabeth Loder, who reviewed our early manuscripts and encouraged me to continue. I also wish to thank Springer for their continued interest in our book. I'm also greatly indebted to Dr. Richard Marcus for his encouragement and helping to provide additional materials that Dawn had yet to send me. But most of all I'm grateful for the opportunity I had to know and work with Dawn. It is to her, her work, and our patients that this book is dedicated.

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Contents

Sorting Through Headache Patterns

1

Key Points

- Receiving a clear diagnosis is often a major reason patients seek headache consultation.
- Most patients seeking treatment for nontraumatic headache have migraine.
- Brief screening questionnaires have been validated for migraine diagnosis.
- Red flags help distinguish important secondary headaches.
- Be sure to let patients know what they do not need to worry about.

When a patient's primary complaint is headache, identifying the reason behind the consultation is essential:

Why are you here for your headache TODAY?
What is worrying you about your headache?

Doctors often assume patients are seeking pain relief; however, the motivation that brought the patient's headache concern to medical attention may be other factors. Directly asking, "Why are you seeing me about your headaches *today*?" can provide important information patients may not have otherwise divulged (Table 1.1). Failure to discover these types of concerns can be a missed opportunity to help uncover and address important issues.

Reasons for headache consultation often differ between emergency department (ED) and outpatient visits. According to data from the National Hospital Ambulatory Medical Care Survey, head pain is the fifth leading cause of emergency department visits in the United States, resulting in over four million ED visits annually [1]. Among patients ages 15–64 years old, head pain is the third leading cause for an ED

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Table 1.1 Why are you seeing me about your headaches *today*?

Common reasons	Example	Action plan
Headache is unchanged, but the patient is now concerned	Her favorite celebrity has headaches and was just diagnosed with cancer Her employer is threatening to fire her if she keeps missing work for headaches	Discuss results of your examination in detail Provide a diagnosis or plan to clarify a diagnosis Address specific treatment needs that will reduce disability
Headache is unchanged, but the patient wants a different treatment	She saw a commercial on television promising quick headache relief Her friend tried a new treatment that worked well The patient has reached her "last straw" and is no longer able to tolerate current level of relief	Review current treatment regimen Discuss alternative treatment options
Headache pattern has changed	Headaches have become more frequent, longer, or severe or less responsive to treatment New symptoms have developed, e.g., aura or new neurological or medical symptoms	Perform more detailed examination of history and physical examination Determine the need for additional testing Share results of above with patient

visit for women and the fifth leading cause for men. In a survey of 859 participants of the American Migraine Prevalence and Prevention study who had visited an ED at least once during the previous year, the main reasons given for an ED headache visit were [2]:

- Unbearable pain (79 %)
- The patient could not contact her primary provider (63 %)
- The patient wanted "better" or different medications (26 %)
- The patient was concerned about the significance of the headache (23 %)

Initially clarifying whether the visit was precipitated by a change in headache pattern or severity or another reason is important to focus the evaluation and workup appropriately.

Outpatient consultation is often sought to help clarify the reasons headaches are occurring. Overriding concerns identified in a prospective study investigating why patients seek primary care consultation for headache ($N=489$) included [3]:

- Understanding what was causing the headaches (80 %)
- Knowing if there was a "headache cure" (66 %)
- Learning about effective treatments (60 %)

About two in three people rated both receiving an explanation about the cause of headaches and receiving effective relief as important aspects of their consultation

visit. People were more likely to consult if they were anxious or depressed or there had been high headache-related frequency, pain, or disability during the previous 3 months.

A subsequent survey of 100 consecutive adult patients with migraine found that patients likewise rated receiving an explanation for the cause of their migraines as very important (scoring 4.7 on a 5-point Likert scale) [4]. Patients were provided with 4 explanations of migraine causes, ranging from 25 to 245 words. The briefest description stated, "Migraine patients have a hyperexcitable brain that reacts more intensely to stimuli. The headache is due to an inflammation of the lining of the brain". The longest description described migraine as a genetically predisposed abnormal hyperexcitability, providing detailed descriptions of pathological findings discovered in migraine brains, common triggers, how hyperexcitability results in pain, environmental sensitivities, nausea, etc., and how treatment addresses eliminating triggers and reducing brain hyperexcitability. Patients preferred the longer more detailed explanations, with 56% preferring the 245-word explanation, 30% the 117-word description, 10% the 105-word explanation, and 4% the 25-word description. Preferences were unaffected by educational level. This study also highlighted that both newly diagnosed and patients with established migraine diagnoses benefit from receiving migraine information. In this study, newly diagnosed migraineurs and those who were already established migraine patients were equally likely to find that the explanations contained information that was new to them.

Providing direct answers about the causes of chronic headache can be both informative and therapeutic. For example, completing a single, 30-min educational session about migraine and medication use with an allied health care worker along three follow-up telephone calls resulted in a 47% reduction in headache activity compared with an 18% headache reduction in patients receiving only the doctor visit without supplemental education [5].

What Patients Want to Know: Brain Tumor Versus Migraine

Many patients consulting for headaches fear that headaches may be a sign of a brain tumor. Perhaps the patient's headache seems similar to those portrayed by an actor on television whose character was later found to have a tumor. When brain tumor is a concern, patients often need to directly hear that they do not have a brain tumor before they can focus on discussions about whether or not their headache may be migraine.

One of the first steps in headache education is helping patients understand what they should not be worrying about. Patients need to be directly told that their headaches are or are not caused by an underlying medical condition. Common secondary headaches include trauma, infection, hemorrhage, or tumor. Headaches not caused by an underlying, identifiable pathology are primary headaches, such as migraine, tension-type, and cluster headache. Although testing with blood work, neuroimaging, etc., will be normal, primary headaches do represent real, biological conditions. These conditions, however, are headache-only disorders rather than disorders

Table 1.2 Differences among common primary headaches

	Tension-type	Migraine	Cluster
Frequency:	High	Low	Clusters
Duration:	Very long or constant	Moderate	Very short
Severity:	Mild	Moderate-severe	Excruciating
Autonomic symptoms:	None	Some	Marked
Attack-related disability:	None	Moderate-severe	Very severe

Table 1.3 Distinguishing among common primary headaches in adults

Headache type	Pain location	Duration (h)	Headache-related behavior
Migraine	Often but not always unilateral, often temple or side of head or face If unilateral, affected side should vary at least occasionally	4–72	Reduced productivity, lies down, seeks dark and quiet isolation May place washcloth over forehead and eyes and go to sleep May be nauseated although vomiting usually only with very severe episodes
Tension-type	Bilateral, often forehead or like a band around the head	8–24 or constant	No interference
Cluster	Unilateral eye with pain typically affecting the same side	½–2	Agitated, avoids laying down, paces, smokes, showers, hits head

associated with other pathology. Primary headaches can be distinguished by characteristic differences in headache patterns [6].

> When headache is not secondary to another health condition, directly tell your patient, "Your headache is not caused by a medical disease or brain problem. You have no scary neurological abnormalities on your examination to make me think the headache is caused by another serious health problem."

Common Headache Diagnoses

Commonly occurring headaches are differentiated based on their patterns. While the vast majority of patients seeking treatment for nontraumatic headache will have migraine, other primary or secondary headaches may be present. Common primary headaches, like migraine, tension-type, and cluster, are distinguished by attack frequency, severity, duration, autonomic symptoms, and attack-related disability (Table 1.2). Frequency and duration decrease along a spectrum from tension-type to migraine to cluster headaches, while severity, the presence of autonomic symptoms, and attack-related disability increase. Pain locations and typical attack-related behaviors also differ among these types of headache (Table 1.3). In addition,

Table 1.4 Migraine in adults vs. children or adolescents

	Adult	Pediatric
Location	Unilateral	Usually bilateral. Often forehead pain. Occipital migraine is rare and warrants additional evaluation
Duration	4–72 h	2–72 h
Associated symptoms	Photophobia and phonophobia are usually present	Children rarely verbalize sensitivity to noise and lights; photo- and phonophobia may be inferred from behavior (e.g., retreating to dark, quiet room; turning off television or computer)

Based on data from Headache Classification Committee of the International Headache Society [7]

migraine features in children and adolescents <18 years old often differ from those seen typically in adults (Table 1.4) [7].

Migraine

Migraine is an intermittent, disabling headache (Box 1.1) [6, 8, 9]. Migraine pain is often pulsing or throbbing and may affect only one side of the head. Both sides of the head may also be painful. During an attack, migraineurs are typically overly sensitive to a wide range of sensory stimuli, often describing sensitivity to touch (allodynia), finding conversational speech sounds painfully loud (phonophobia), marked sensitivity to normal room lighting (photophobia), and sensitivity to smells or odors (osmophobia). Allodynia may be experienced as a sensitivity to light touch or clothing touching the skin, pain with brushing the hair or wearing glasses, or a feeling that "my hair hurts."

Box 1.1 Typical Migraine Features Based on Evaluation of 1283 Adults with Migraine[a]

- Frequency—2 days per month.
- Pain location—usually unilateral (67 %) affecting eyes (67 %), temporal area (58 %), or frontal area (56 %). Neck and back of the head are affected in about 40 %.
- Time to peak intensity—≤1 h for 48 % of migraineurs.
- Peak intensity rating—7 on a scale from 0 (no pain) to 10 (excruciating pain).
- Headache duration—average 24 h.
- Disability—only 31 % could still function with a migraine.

[a]Based on [6, 8, 9]

For most patients with migraine, attacks occur less than 2 days per week. Migraines can be divided by attack frequency into episodic (<15 days per