MIGRAINE AND TENSION-TYPE HEADACHES

MIGRAINE AND TENSION-TYPE HEADACHES, AND THEIR COMBINATION AFFECTS ON HEALTH OUTCOMES, QUALITY OF LIFE, AND PRODUCTIVITY

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Migraine and tension-type headaches (TTH) account for the great majority of headaches, and chronic headache is one of the most common pain syndromes in industrialized countries. Only a small percentage of people with migraines, however, actually seek medical attention for pain relief, so it is a highly undertreated condition. It is thought, therefore, that chronic headache affects quality of life and also productivity. Studies of 408 employees at the Technical University of Dresden and University Hospital Dresden in Germany evaluated the productivity and quality of life, as well as health outcomes, of individuals suffering from migraine (62.4%), TTH (19.6%), or a combination of the two (18%). These employees were selected because they had responded to a questionnaire containing a short version of the Kiel Headache Questionnaire (based on diagnostic criteria established by the International Headache Society [IHS]) as a diagnostic tool. These employees also had completed the quality-of-life Short Form 36 (SF-36) questionnaire, and had answered additional non-standardized questions about satisfaction with therapeutic options and outcomes, and about concerns over workplace absenteeism.

IMPACT ON PRODUCTIVITY AND QUALITY OF LIFE

Overall, responses to the SF-36 questionnaires and queries showed that the study population had scores in all productivity and quality-of-life domains that were substantially lower than normative values for a healthy German population. Analysis of the results by headache type showed that individuals with migraine and combination headache were markedly more impaired than were individuals with TTH, especially in categories such as pain, role emotional, and social functioning. Not surprisingly, the degree of impairment was closely related to the severity of the headache, particularly for physical functioning, pain, role physical, role emotional, and social functioning.

The study also assessed the impact on missed days from work and lower productivity, as measured by lost workday equivalents (LW DE), which accounted for both missed days and days at work with reduced effectiveness because of headaches. The participants lost an average of 2.67 hours of work in 4 weeks and worked another 25.6 hours at a level of productivity that was 72.4% of peak productivity. The LW DE was 10 hours (median 4.25 hours). Corresponding data for home life showed a loss of 10.3 hours of “work” time and an LW DE of 14.7 hours owing to 12.9 hours spent operating at 63.4% of peak productivity.

The LW DE at the workplace was 10.3 hours for employees with migraine, 10.7 hours for the people diagnosed with TTH, and 8.7 hours for the individuals with combination headache. LW DE values for home life were 15.3 hours for the people with migraine, 13.9 hours for those with TTH, and 14.6 hours for the individuals with combination headache.

HEALTH OUTCOMES

Of the 408 respondents, 33% described their initial pain as moderate, whereas 65% said it was severe, indicating that those with greater suffering from headache pain participated in the survey. Forty percent of the respondents who had severe headache before taking medication continued to suffer from moderate to severe pain after taking medication. The continuation of
SELECTED POSTERS

MODERATE TO SEVERE HEADACHE PAIN DESPITE THE USE OF RELIEF MEDICATION WAS ALSO REPORTED BY 38.6% OF THE EMPLOYEES WITH MIGRAINE, 18.1% OF THE EMPLOYEES WITH TTH, AND 33.8% OF THE EMPLOYEES WITH A COMBINATION OF THE 2 TYPES OF HEADACHES.

Most of the medications taken by the respondents were reportedly over-the-counter (OTC) medications. Only 11.6% of respondents with migraine, 2.7% with TTH, and 8.8% with combination headache took prescription medication. In fact, more than 50% of the medication taken was OTC, most of which were analgesics, followed by ergotamine and triptans.

It is therefore not unexpected that 83% of the survey respondents were not currently receiving medical treatment for their headaches. Almost one third had never seen a doctor about their headache problems, mostly because, as the patients indicated, they saw no need or they felt a sense of futility regarding what the physician could actually do for them.

Perhaps what is most remarkable about the data is that almost half of the participants gave their medication a poor rating, and less than 5% were highly satisfied with their actual treatment. Clearly, these data support the concept that migraine and other headache disorders are underdiagnosed and undertreated. Besides proper diagnosis and the desire for effective therapy, it appears that clinicians face the obstacle of teaching patients that their headaches can be more optimally managed. Poor treatment and minimal physician interaction can lead to significant loss of workdays, productivity (at home and work), and quality of life.

MIGRAINE PREVALENCE AMONG HEADACHE SPECIALISTS:
DOES MIGRAINE AFFECT THEIR VIEWS ON TREATMENT?

Based on a poster presented by RW Evans and RB Lipton

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In a survey of 42 headache specialists attending a meeting for the faculty of the Neurology Ambassador Program in April 2000, 33 specialists (79%) responded. The results showed that the lifetime prevalence of migraine was almost 5 times higher in female headache specialists, and more than 12 times higher in male headache specialists compared with the general population, which is 6% for men and 18% for women. The respondents were predominantly men (n = 24; women n = 9).

Approximately half of the respondents indicated a preference for tricyclic antidepressants (TCAs) for preventive therapy, followed by beta-blockers, verapamil, divalproex, and selective serotonin reuptake inhibitors (SSRIs) in that order. For treatment of basilar migraine, divalproex was deemed the most effective compared with verapamil, TCAs, and beta-blockers.

Interestingly, the respondents were equally divided regarding several treatment decisions. Roughly one third considered triptans to be safe for treatment of headache in basilar migraine after resolution of neurological signs and symptoms; another one third of the respondents considered triptans to be unsafe, and the remaining respondents were not sure or did not know. The respondents also were equally divided over the issue of whether low-dose oral contraceptives (OCs) significantly increase the risk of stroke in migraineurs. Approximately one half agreed and approximately one half disagreed; only 6% indicated that they were not sure or did not know. However, most respondents felt that OCs are safe in migraine with aura that lasts less than 1 hour in the absence of other risk factors, and all agreed on the safety of OCs in migraine without aura in absence of other risk factors. The 5 most important factors affecting initial treatment decisions as ranked in descending order of importance by the respondents were headache-related disability, average severity of migraine pain, comorbidities, pattern of associated symptoms, and migraine subtype.

CHARACTERISTICS OF A HEADACHE CONTINUUM BETWEEN MIGRAINE AND EPISODIC TENSION-TYPE HEADACHE

Based on a poster by ELH Spierings
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Migraine and episodic tension-type headache (ETTH) can be thought of as 2 ends of a headache continuum, with chronic TTH (CTTH) with or without coexistent migraine in the middle. CTTH is a daily or almost daily headache condition. Patients can develop headaches on this continuum in either direction.

The development of migraine, ETTH, and CTTH on the headache continuum was evaluated in 258 patients with headaches at least 5 days per week. Of these patients, 37% said the onset of head pain was abrupt, while 63% developed pain gradually. Of those who developed migraine or ETTH abruptly, one fifth had a history of severe headaches, whereas 67% of the individuals with gradual-onset migraine or ETTH initially had severe headaches. Individuals starting the headache continuum with intermittently severe headaches had headaches that were associated with significantly more nausea and vomiting than with mild headaches, suggesting that the mild headaches were ETTH and the more severe headaches were migrainous headaches.

Three fourths of the patients who had resumed to having intermittent headaches initially had migraine and presented with migraine at follow-up; however, only 43% of the patients with ETTH initially had ETTH at follow-up.

These data suggest that the development of (almost) daily headache from intermittent headache is independent of the nature of the initial headache. A significant proportion of (almost) daily headaches, however, reassume the nature of the initial headaches when they become intermittent.