



NHF Insights™ Healthcare Provider Series
Why Primary Care Providers Should Treat Headache Disorders

Hope O'Brien, MD:

Welcome to NHF Insights, the National Headache Foundation's podcast created with the support of our industry partners. We bring you fireside chats with experts on what's new in migraine and headache care. I'm your host, Dr. Hope O'Brien. I'm a board-certified neurologist and headache specialist and board president of the National Headache Foundation.

This episode is about why providers should care about headache disorders and is a part of our Healthcare Providers Series. Today, we'll explore the real impact of migraine and why it's underdiagnosed and undertreated, the role of primary care providers, particularly those who are advanced practice providers, and how early action can change patient outcomes.

Let me introduce today's guest, Dr. Vince Martin. Dr. Martin is a primary care physician and UCNS and AQH certified in headache medicine. He is professor of medicine at the University of Cincinnati, based in Ohio. He is co-director of the Headache and Facial Pain Center. He is nationally and internationally recognized as an expert in headache medicine, and he is the former board president of the National Headache Foundation. Welcome, Dr. Martin.

Vince Martin, MD:

Thanks, Hope. It's a real pleasure to be here.

Hope O'Brien, MD:

So as an internal medicine physician, you see a wide range of conditions in a very busy practice. So, what drew you to headache medicine?

Vince Martin, MD:

Well, I think a couple of things. One is I had migraines myself and I had episodic migraine prior to my residency training. And then with all the things that provoke migraine during residency, my headaches evolved into something called chronic migraine, which are people that have more frequent migraines that are more disabling. And being a great patient, I really didn't do anything for about ten years myself.

And then one day I woke up and I said something has changed. And I was like, oh, I don't have a headache because I had a headache most of the time. And I didn't even take as much as an aspirin for them. Then I thought to myself, it was kind of one of those self-reflection moments, like, I can either not do anything and live with these chronic headaches almost every day, or I could do something about it. So that was one kind of motivating factor, was the migraine had a very significant impact on my life.

And then just to kind of follow that up, when I finally got my migraines under control, that was the most important healthcare improvement in my entire life. And for people that don't have migraine, they don't really quite understand that. So, I had a real strong interest there. My wife also suffers from menstrual migraines, and she was getting more frequent migraines, so I had my own personal interest for getting involved.

Hope O'Brien, MD:

Dr. Martin, we know that migraine affects 39 million patients here in the US, probably more than that. And we know it's also under-recognized, underdiagnosed. Why do you think that is?

Vince Martin, MD:

I think there's a number of different factors. I think number one, I think that many patients are treating their migraines with over-the-counter medications and they may not recognize that there are better alternatives. I think second of all, some of them have had bad experiences in our healthcare system where they'll come in and maybe they feel like maybe the physician or healthcare provider was not as attentive, or maybe even as knowledgeable about their disease as maybe they should be. And three, some of the medications that we use, particularly preventive meds can have bad side effects, things like weight gain and memory loss and kidney stones and so forth. Maybe they've experienced some sort of side effect that kind of turns them off to the medical system. So, I think there's probably a variety of different things that cause underdiagnosis of migraine.

I think the other thing is the diagnostic criteria, I think that it can be so complex that most primary care providers, who are usually the initial physician that is consulted for a headache complaint, they don't know the criteria for migraine, so consequently they're diagnosing migraine by pattern recognition. So whatever their pattern that they think is a migraine, so they might think well it has to be a one-sided headache to be a migraine, or you have to have a visual aura to have a migraine, or it might need to be throbbing to have a migraine, when in reality you're going to miss 35 to 40% of all cases, or even more if you only use that one specific symptom as your definition for having a migraine.

Hope O'Brien, MD:

And we know that migraine can play a significant role in a patient's day-to-day life. And unfortunately, we don't get that much education in migraine when we're doing our clinical training. So where do you think training for migraine should start?

Vince Martin, MD:

I think there's a number of different levels. I personally think that the general population should be educated on what is a migraine since it's such a common disorder in the population. But certainly, healthcare providers, it should start first in medical school, where the medical students should get some training on migraine and how to manage it. But then in residency training, particularly in primary care practices and neurology practices in particular, there should be more education for migraine. And even in the attending physicians, I had like an hour's worth of migraine lectures prior to going out in private practice, which obviously is not adequate. But there is an opportunity to train primary care providers even after they've completed their residency training.

Hope O'Brien, MD:

And unfortunately, there's a lot of stigma behind migraine. And I'm just curious to see whether or not that has changed since you started practice in migraine. What are some of the things we can do to combat that?

Vince Martin, MD:

Honestly, in my opinion, the biggest stigma is within the providers themselves. For some reason, migraine is kind of lumped in with other pain disorders. And migraine patients are viewed as drug seeking or difficult patients with lots of MyChart messages. And some PCPs have this opinion of migraine patients that causes them maybe to back away from management and maybe even learning about the disease.

Hope O'Brien, MD:

In that line of discussion, what would you say to a primary care physician or nurse practitioner who feels like headache disorders are just way too complicated and just not for me?

Vince Martin, MD:

Well, I would say the following. One is it's a very common disease, not only in the general population, but within your primary care waiting room. Then many of these people you don't even know exist. We did a study where we actually stationed a medical student in a primary care practice here in Cincinnati, and we found that the prevalence of migraine was about 33%. It didn't matter what the person was coming in for. And you say, how could that possibly be? And the reason for that is because migraine is associated with all the common primary care illnesses, things like depression, anxiety, back pain, neck pain, irritable bowel syndrome, fibromyalgia, and so forth. So, you tend to get a concentration of patients with migraine in primary care practices.

And what's interesting is when you tell PCPs that, they're like there's no way that a third of my patients have migraine. But the reality is they do, but they may not always be complaining about that. The second thing is that the patients are kind of reluctant to talk about it within the primary care practices as well. But I would say that migraine is one of the most common complaints in a primary care practice, and the disability that migraine produces in your patients is something you would definitely want to try to prevent. So, I think for all those different reasons, I think migraine is worthwhile for improving your care and improving the lives of your patients.

Hope O'Brien, MD:

You are a very busy primary care physician, and you've told me how many patients you see in your practice. It's unbelievable. So how do you find the time to make the diagnosis? And what would you say to a busy primary care provider? How do you make it easy?

Vince Martin, MD:

Well, primary care is perfectly stationed to manage migraine patients. For one thing is you don't need to do it all in one visit. One visit could be making a diagnosis, one visit could be acute therapy, one visit

could be preventive therapy. So, the PCP has the advantage of managing a disease over time. So, it's different than a specialty practice where you might have 45 minutes or an hour seeing the patient the first time. So that's one concept, is longitudinal care.

The second thing is there should be certain images of migraine different than what we talked about before that should tip off a PCP that they're probably dealing with migraine. One is if they have nausea with their headaches, that significantly increases the likelihood of having migraine. We did a study in about 1500 patients in four different populations, and there was over an 80% chance that they had migraine if they had a single symptom of nausea.

ID Migraine is a brief screener where they also use nausea, photophobia, which is sensitivity to light, and disability, so what impact they have. If they have two of those three criteria, they too had about an 80% plus likelihood of having migraine. So, there are some simple tools that you can use to try to diagnose migraine in your practices.

Hope O'Brien, MD:

And how do you differentiate between a migraine which is a primary diagnosis versus let's say a secondary headache, a headache that's caused by real pathology?

Vince Martin, MD:

I mean that's a great question. I've educated a ton of primary care physicians, and one of the things they are most concerned about is secondary headache disorders. But yet when you look at studies in primary care, take new onset headache, somebody comes in with new onset headache, the likelihood of them having a secondary headache disorder is less than 2%. Starting, you've got a 98% chance of not having a secondary headache. So, if you have a patient that has a long history of headaches with a stable pattern, that's not likely to be a secondary headache disorder.

So usually, a secondary headache disorder is something where there's a change in the pattern or of an existing headache disorder or maybe a new type of headache. The headache might be in a different location. And then there's something called SNOOP, which some doctors will use for some of the red flags for secondary headache disorder, things like a thunderclap headache which is where the headache reaches peak intensity in less than one minute. That would be significant for things like a subarachnoid hemorrhage or intracerebral hemorrhage. But there's also other differentials. Headaches associated with systemic signs or symptoms. So, you have a new onset headache, and the patient has a fever. Unless they've got like a sinus infection or URI with that, you have to worry about could something else be going on, things like meningitis or brain abscess, etc.

An abnormal neuro exam, so if someone comes in with a new type of headache or something that's changed in their existing headaches, you should do a neuro exam. That's probably the most predictive factor for secondary headache disorders. And then new onset headaches after age 50 would be another one. And there's other flags for both low- and high-pressure headaches as well.

So, I've had patients get headaches that are worse when they stand up and better when they lie down. They may have a leak of spinal fluid. Or the converse where the headaches are worse when they lie down, worse in the morning, worse when they cough, bear down and sneeze, or Valsalva. Those could be high-pressure headaches. So, without going through all the litany of things, I think if you remember

two things, is this a new onset headache or is this headache different than your longstanding headaches. Those are the two things I would tell PCPs to think about in considering a secondary headache disorder, which are very unlikely.

Hope O'Brien, MD:

There may be healthcare providers who strongly believe that headache disorders should be managed by neurologists. Why do you think that that may unintentionally delay care or outcomes for patients?

Vince Martin, MD:

Well, I wouldn't have done all those primary care education if I didn't think that PCPs shouldn't be managing migraine. For one, it's impossible for neurologists and headache doctors to see the 40 million people with migraine in the United States. So, it's not feasible. Second of all, in most headache clinics, there is a six month plus waiting time for patients. And if you're having bad headaches, that is a long time to wait. Three, many of the medications that are used, particularly as preventive and even some acute ones, are ones that PCPs are very familiar with, things like tricyclic antidepressants and beta blockers and topiramate. And now they're starting to learn some of the new CGRP therapies as well, which I'm trying to have higher uptakes in primary care as well. But these meds can easily be used by primary care physicians as long as they know a few basic principles in their use.

Hope O'Brien, MD:

So, because headache disorders will show up in the primary care physician's office first, that's the first person they see, why is it important for the diagnosis to be made there and also the importance of early treatment?

Vince Martin, MD:

Well, there's a number of different ways to respond to that. But I would say that if you don't make the diagnosis early and you allow the headaches to evolve into a chronic migraine condition where they have greater than 15 headache days per month, of which 8 or more meet migraine criteria per month, then the horse is out of the barn. There's structural changes in the brain. The headaches become more recalcitrant to therapy.

And then a very interesting thing starts to happen, and we don't really quite understand it, but a lot of the other associated diseases that we talked about being associated with migraine all of a sudden become a lot more common in those patients. We can't say that that's because of migraine. But it's very interesting, your fibromyalgias and your anxiety and depression and you've got irritable bowel syndrome and so forth. And you get this gemish of really difficult diseases, many of which are hard to treat that start involving the patient.

And the disability that these people have. I think if you have migraine yourself, you know what kind of an effect that these headaches have on you and missing social events. I've had people miss graduations. I've had patients miss their child's wedding. Can you imagine that? These are major events that are being missed, major impact on people's lives, and just with a few basic principles of management, PCPs can learn how to take care of these patients.

Hope O'Brien, MD:

And many of our patients end up in the emergency room, unfortunately. And so, what can primary care providers do to prevent this from happening?

Vince Martin, MD:

Well, you had mentioned early treatment. One is you have to look at migraine as a process or evolution of a disease. If you start off early on where the nervous system is not as sensitized, then the disease becomes much easier to treat. So, if you treat with, say, a triptan, things like sumatriptan or rizatriptan or one of the gepants early on, the patients are less likely to evolve into a more recalcitrant type of headache. And when they get to that recalcitrant stage, they may not respond to their acute meds and they may end up into the ED, which is something you want to prevent because many patients do not have a real favorable experience in the emergency room.

Hope O'Brien, MD:

We talked about a lot during this discussion. And so, if you were to give one advice to somebody who's maybe on the fence about treating or even just diagnosing migraine, what would you say to them?

Vince Martin, MD:

I would say that as a primary care provider, that we are at the forefront of improving the lives of our patients. And just like many PCPs or experts at hypertension and diabetes and asthma, you need to become an expert at managing migraine as well. It's an important disease. It's one of the most common symptoms that patients will present to you in a primary care practice, and it's one that is extremely fulfilling to treat. I mean, I can't tell you how many people have said you've changed my life. I had no life before my migraines were treated. It's a very rewarding experience.

Hope O'Brien, MD:

Thank you so much, Dr. Martin. This has been an enlightening discussion. I appreciate your insights and expertise in highlighting why headache disorders should be a priority in clinical practice.

Thank you to our listeners for joining us. We hope this conversation helps you make an even greater impact for your patients. Also, for your patients, we've created a companion series that will help them recognize symptoms, communicate clearly, and come prepared for visits. Find the full series at headaches.org

Thank you again for listening. Until then, goodbye.

This episode of NHF Insights™ was supported by AbbVie and Pfizer. The content was developed independently by the NHF.

Resources

1. National Headache Foundation website <https://headaches.org>
2. ID Migraine <https://headaches.org/resources/headache-tests>

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