



Deconstructing the Art of Headache Medicine

The author presents 7 tables and commentary for taking a medical history and determining the best strategy for headache management.

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Severe headaches, including migraines, affect nearly 15% of American adults.¹ Migraine headaches are considered to be among the most debilitating physical ailments, responsible for roughly 1.2 million visits to the emergency department (ED) each year and some \$13 billion a year in lost productivity.²

Despite the prevalence of headache disorders and their physical and economic toll, the treatment of these conditions remains largely individualized. More often than not, treating someone with recurrent headaches boils down to a combination of artful clinical care and a thorough

knowledge of the patient's personal history. It tends to be more art than science. Every headache patient is unique and many factors should be considered when choosing the best treatment option for any 1 patient.

This article attempts to deconstruct the thought process that is involved in determining the best strategy for treating headache patients and presents a number of tips for taking a careful medical history of these patients. Of course, it will not always be feasible to obtain the entire history as listed in the tables of this article. However, the more of this information is collected, the better your treatment decisions will be for that patient.

Table 1: History, Headache Characteristic, Frequency

<p>The Headache History</p> <ul style="list-style-type: none"> • How old is the patient? Each decade of age may require a different therapeutic approach. • When did the headaches begin? • How did the headaches evolve? • Have they changed, and if so, can the patient describe the changes? • How are the headaches lately?
<p>Headache Characteristics</p> <ul style="list-style-type: none"> • Type of headache—tension, migraine, or both (or other: cluster) • Severity of the headaches <ul style="list-style-type: none"> ○ How quickly does the headache become severe? ○ How much disability does the headache cause? ○ How often does the patient get very severe headaches? ○ Can the patient tell, and when can they tell, if the smaller headache will progress into a migraine? • Aura: How severe and prolonged are neurologic symptoms? • Is there nausea and vomiting? Does it bother the patient? Does the patient want nausea treated (some do not)? • Which headache type is the most troubling? Which needs to be the focus of treatment? Or are both small and major headaches a problem?
<p>Frequency of Headaches</p> <ul style="list-style-type: none"> • Severe migraines: How often? • Milder or moderate migraines: How often? • Milder headache (usually “tension or CDH”): Is it daily, or almost every day? How much does it bother the patient? • Prolonged headache <ul style="list-style-type: none"> ○ Does the patient have long (2, 3, 4+ days) migraines? ○ How often do these occur? ○ What has worked in the past for these? ○ Have corticosteroids helped?

CHD, chronic daily headache.

Table 1: History, Headache Characteristic, Frequency

We treat patients very differently at age 15, 30, 60, or 80. With advancing age, for example, our medication options dwindle. Not enough has been written about headache treatment in the elderly, where our medication choices are limited.

When taking the history of a patient with recurrent headaches, the logical place to start is with the simple question: When did the headaches begin? New onset daily persistent headache (NDPH) and post-traumatic headaches are more difficult to treat than are transformed migraines. How recently the headaches began, and how they have evolved, drives therapy. Some patients are not bothered by their chronic daily headache (CDH) and want to focus instead on the severe migraines. Others may state, “My migraines are well controlled, it is the CDH that is the main problem.”

The type of headache (migraine, tension, cluster) is

important, as is the severity—about 60% of patients report pain isolated to one side of the head, and for 15% of patients, the headaches occur only on that side.³

Aura occurs in approximately 25% to 30% of patients with migraines, although most of these patients also experience migraines without aura.³ The presence of an aura, and how severe and prolonged the neurologic symptoms may be, affects treatment.

Other factors that influence treatment choices include the presence of nausea or vomiting, and how severe these may be; how quickly the headache escalates; and the degree of disability. When (and if) the patient can tell if the headache is becoming severe is a determining factor. The frequency of moderate-to-severe headaches drives treatment. Prolonged (2 days or longer) headaches may require a different strategy. Because treating patients with headaches is so complex, we need to inquire about what has helped, or has not been effective, for the longer headaches.

Table 2: Refractory, Triggers, Special Situations, Past and Current History

Refractory migraines are defined as headaches that fail to respond to an adequate course (typically 2 months or more) of at least 2 of 4 classes of preventive medication.⁴ The prevalence of refractory migraines remains unknown, but the condition affects a small subset of people with chronic migraines. “Refractory” does not necessarily imply severe; some patients experience moderate or mild headaches that nevertheless do not resolve with treatment.

Does the person have “difficult to treat” refractory headaches? If so, how refractory? Mild, moderate, or severe? Determining this involves the number of years of severe headaches, medical and psychiatric comorbidities, number of days per month with severe head pain, and other factors.

Triggers

Some (but not all) triggers may affect our treatment choices. These include menses, stress, and exercise. If stress is a trigger, addressing the underlying cause of stress and ways to address stress through therapy, meditation, exercise, or medications may help.

Special Migraine Situations: Preventive Therapies

For patients who have a known history of migraines centered around a specific event, it may be possible to prescribe preventive therapies for those occasions—these medications can be taken in advance of the event and then stopped afterward. For example, if a woman suffers from prolonged menstrual migraines, we may choose to use preventive medications prior to and after the expected onset

Table 2: Refractory, Triggers, Special Situations, Past and Current History

<p>Refractory Headaches</p> <ul style="list-style-type: none"> • Does the patient have “refractory, difficult to treat” headaches? • If so, how refractory (mild, moderate, severe)? • How long have the headaches been refractory?
<p>Triggers</p> <ul style="list-style-type: none"> • Which triggers are the most important for the patient? • Can the patient do anything about his or her triggers? • What are the patient’s main stressors? Has the person addressed the stress?
<p>Special Migraine Situations</p> <ul style="list-style-type: none"> • Are the following an issue? <ul style="list-style-type: none"> ○ Menstrual migraine (How severe, how prolonged, has anything helped?) ○ Prolonged headache (Has any medication helped?) ○ Exertional headache ○ Altitude headache
<p>Past Medication History</p> <ul style="list-style-type: none"> • OTCs: What worked or did not help? • Abortives: Why did the patient discontinue? Lack of efficacy or side effects? • Preventives: Why is the patient no longer taking the medication? Did the preventive help, but decline in efficacy? Side effects? • Did the patient have Botox? How much, and how many times? • Did the patient try nerve blocks/trigger point injections, sphenopalatine ganglion blocks?
<p>Current Medication History</p> <ul style="list-style-type: none"> • Preventatives: Are the preventive(s) helping? How about side effects? • Abortives: Do any OTCs help? What abortives are working? How about side effects? • Do the current medication(s) help with comorbidities?

OTC, over the counter

of the pain. Prolonged headache may necessitate a different approach (particularly with regard to the use of low-dose cortisone). Exertional or sexual headaches may be amenable to preventive medications taken just prior to the activity. Altitude headache is often relieved by acetazolamide and/or dexamethasone.

Past Medications

What worked and did not work needs to be explored. Efficacy and side effects of over-the-counter (OTC) medications are important to evaluate, as well as prescription medications and supplements. Outside of the medications, it is helpful to know whether the patient has had any experience with onabotulinumtoxinA (Botox) and nerve blocks, and what the outcomes were.

Current Medications

When first seeing a patient with refractory headaches, we do not want to change all of the patient’s medications during the first visit. Rather, we ask: Are the current preventives helping? And has the patient been on an adequate dose? Side effects are crucial to list. We may not discontinue a particular medication, but we might state in the chart “cannot increase the medication due to (this) side effect.” If preventives are helping with psychiatric or medical comorbidities, we may continue the medication, even if it is not helping the head pain.

Table 3: Family History, Emergency Department, Herbs and Vitamins, Nonpharmacological, Patient Input

A close family member’s response to medications may influence our treatment. For instance, an 18-year-old patient comes in with her mother, and we mention topiramate (Topamax), which is approved for the prevention of migraines in people 12 years and older. When the mom states, “Topiramate almost killed me, I crashed my car on it,” we probably should not prescribe topiramate for the daughter. This is partly due to genetic polymorphisms that affect medication response in mother and daughter. But also there is the “nocebo by proxy” effect: The mom had a terrible experience, and the daughter knows that; therefore, she is unlikely to have a positive experience. By contrast, if the mom had an excellent experience with topiramate, we may encounter the “placebo (positive) by proxy” response.

Emergency Department Treatment

It is helpful to know how often, if ever, the person goes to the ED. We need to ask what treatments did work, and which did not (or caused side effects). This will influence what medications we prescribe as end-of-the-line therapy: what to take when nothing is helping. In addition, the physician should note if drug-seeking behavior is suspected.

Herbs, Vitamins, and Non-Prescription Treatments

Feverfew, Petadolex (butterbur), and magnesium oxide have all proven effective as migraine preventives in double-blind studies. Of these, Petadolex has been the most effective. Petadolex, a purified form of the herb butterbur, is made of extracted plant. The patient should be asked whether he or she has tried Petadolex or the parent compound butterbur. Occasionally the other “natural” compounds may help: feverfew, vitamin B2, and magnesium. We attempt to ensure that all patients are on adequate doses of vitamin D. Some patients ingest large quantities of “natural” herbs and vitamins. We need to know what types of herbs and vitamins

Table 3: Family History, Emergency Department, Herbs and Vitamins, Nonpharmaceutical, Patient Input

<p>Family History and Response to Medications</p> <ul style="list-style-type: none"> • Close family members: headache history • What medications have worked/not worked? • Which side effects has the patient had to medications?
<p>Emergency Department (ED) Treatment</p> <ul style="list-style-type: none"> • Has the patient gone to the ED? • How often has the patient been to the ED? • If so, what works? What does not work? • Do you suspect any drug-seeking behavior?
<p>Herbs and Vitamins</p> <ul style="list-style-type: none"> • Has the patient tried butterbur (Petadolex), feverfew, vitamin B2, and/or magnesium? • Is the patient taking vitamin D? • What other vitamins or supplements is the patient using?
<p>NonPharmacologic Treatment What has the patient tried?</p> <ul style="list-style-type: none"> • Meditation • Physical therapy • Biofeedback • Exercise • Chiropractic treatment • Acupuncture • Massage • Other
<p>The Patient's Input</p> <ul style="list-style-type: none"> • Is the patient willing to take daily medications? • Is the patient willing to try an injection, nasal spray, and/or suppository? • Is the patient willing to try Botox or nerve blocks? • Other patient preferences: <ul style="list-style-type: none"> ○ "I don't want to gain/lose weight" ○ "I cannot afford to be tired or spacy" ○ "I only want to try natural products"

The Patient's Input

The patient is a full partner, so physicians need to be flexible and listen to their patients. Many patients do not want to be on daily medications, Botox, or nerve blocks. Some patients are unwilling to use nasal sprays, injections, or suppositories. Many will not take any medication that may cause weight gain. If the person only requests "natural" remedies, we will go that route.

Table 4: Psychiatric, Addiction, Personality, Psychiatric Medications

Patients with migraines experience a great deal of disability related to their chronic headaches, including anxiety, depression, bipolar spectrum, personality disorders (PDs), somatization, and post-traumatic stress disorder. Significant abuse in childhood, whether sexual, physical, or emotional, may predispose a person to the development of central sensitization syndromes, such as chronic migraine, fibromyalgia (FM), irritable bowel syndrome (IBS), chronic pelvic pain, and temporomandibular disorder (TMD). Therefore, in my opinion, these are the most important comorbidities to explore.

If there is a history of depression, a number of crucial questions must be asked, such as:

- When did the depression begin?
- Do you have a family history of depression?
- How severe and frequent is your depression, or is it dysthymia (examine further to rule out bipolar disorder)?
- Has psychotherapy been helpful?
- Have you had a positive response to medications; if so, which ones?
- Have you had suicidal thoughts?

The most important questions to ask are those to determine whether the person fits into the bipolar spectrum. The more severe end (bipolar 1) is not often missed; it is the milder end that is often overlooked. Asking a significant other (spouse, partner, parent, caregiver) about the patient is crucial. The clinical stakes for missing bipolarity are enormous.

After inquiring about depression, the physician needs to diagnose anxiety; separating into mild, moderate, and severe is clinically useful. Determining whether the patient has generalized anxiety disorder, social anxiety, and/or obsessive-compulsive disorder (OCD) may drive treatment choices.

Approximately 5% of chronic headache patients have a moderate or severe PD. There is no easy screening procedure for PD traits. It may take the clinician many months to determine if the patient has a PD. Family history may help. PD is often a spectrum, with patients exhibiting characteristics from several categories (borderline, antisocial, narcissistic, etc). It is vital to be on the lookout for PD characteristics in

they are consuming. Most of the time, we will discontinue all vitamins (except D) and most herbs.

Has the patient been trying to actively cope with headache pain, or has he or she been relying solely on medicine? Many chronic pain patients lack coping skills, but developing coping skills may be key to improving a patient's quality of life. The various active coping strategies include, among others, exercise, and mindful meditation. In addition, physicians should ask whether physical therapy (PT), biofeedback, acupuncture, massage, or chiropractic adjustments have been helpful. Depending upon the location, type of pain, and comorbidities, we may suggest one or more of these modalities. The biggest barrier to the use of nonpharmacologic treatment, however, is access and financial coverage.

Table 4: Psychiatric, Addiction, Personality, Psychiatric Medications

<p>Psychiatric Comorbidities</p> <ul style="list-style-type: none"> • History of anxiety and/or depression? If so, rule out bipolar disorder. • History of PD or exhibits PD traits? • History of ADHD, family history of ADHD (including the patient's children)? • Family history of psychiatric conditions? • Has the patient had psychotherapy? What was his/her experience? • Has the patient had suicidal thoughts in the past? • History of abuse as a child?
<p>History of Addiction</p> <ul style="list-style-type: none"> • Does the patient smoke cigarettes? • Does the patient drink? If so, how much alcohol does he or she drink? • Does the patient have a history of addiction? If so, to what drug, how long ago, and did he or she undergo psychotherapy/a rehabilitation program? • Is there a family history of addiction (alcohol or drugs)?
<p>Personality Traits</p> <ul style="list-style-type: none"> • What is your assessment of the patient's personality? Is he or she Type A, hard-driving, perfectionistic? • Is he or she dependent or avoidant? • Resilience, Catastrophizing, Acceptance <ul style="list-style-type: none"> ○ What level of resilience does the person have? ○ Despite headaches and/or psychiatric issues, is the patient functioning, doing well, or on disability and under-functioning? ○ Is the person catastrophizing? ○ What level of acceptance does the patient have?
<p>Psychiatric Medication History</p> <ul style="list-style-type: none"> • Which medication(s) has the patient tried? • Efficacy? • Side effects? • Family history of response to psychiatric medications? • Is the patient willing to take appropriate psychiatric medications?

ADHD, attention deficit/hyperactivity disorder; PD, personality disorder

order to help and protect the patient. In addition, people with a moderate or severe PD may be dangerous to the clinician and staff (legally, emotionally, and [occasionally] physically).

Determining whether the patient has attention deficit hyperactivity disorder (ADHD) is vital, as our treatment options may change. ADHD is encountered in 4.7% of adults and is often undertreated.

In addition to psychological disorders, it is also helpful to note if the patient has a hard-driving, Type A personality (common among migraineurs). The most common PD traits are avoidant and dependent; these traits may affect our therapy.

Psychiatric Medications

As noted in the depression questionnaire above, assessing efficacy and side effects of psychiatric medications must be done prior to outlining a logical medication plan. Patients often relate their response to antidepressants as "mind racing, up all night, I felt crazy." That reaction is a solid indication for bipolarity. Family history of response to psychiatric medications also drives treatment. Some patients are unwilling to take antidepressants, and this input must be taken into consideration.

History of Addiction

Knowing the addiction potential of the patient may influence treatment. Smokers have a higher potential for addiction. In addition, if someone is still smoking, we may work with that patient on picking a cessation program and quitting. If someone drinks more than minimal alcohol, this may steer us away from certain medications. Family history of addiction should be taken into consideration, and patients should be screened for risk factors.

Resilience, Catastrophizing, Acceptance

The level of the person's resilience is important. How resilient the patient is may influence our goals for that patient as well as drive us in certain directions (such as psychotherapy). Catastrophizing is a major contributor to disability. We can work on "turning down the catastrophizing dial." "Catastrophizing by proxy" is also encountered among parents of adolescents with severe headaches. Acceptance is an important construct to assess. The road to acceptance often is paved with many stops in various clinics. By increasing the level of acceptance, we alleviate some of the angst that accompanies chronic pain.

Table 5: Medical Comorbidities, GI, Weight, Sleep, and Fatigue

Patients with migraines often have more than 1 medical condition. As noted, chronic pain that has become centralized

(central sensitization) often includes a myriad of problems: IBS, chronic fatigue, and fibromyalgia. With fibromyalgia, we may utilize medications, PT, exercise, injections, etc. For patients with TMD, the presence of clenching and bruxism influences treatment choices. For the jaw pain, PT, medications, and Botox are considerations. In addition, patients with various immune disorders (lupus, rheumatoid arthritis, Sjögren's syndrome) often suffer from severe, refractory headache.

A patient's medical history of comorbidities often determines which medications are used. If a patient has hypertension, for example, we may choose between beta blockers, calcium channel antagonists, or angiotensin II

Table 5: Medical Comorbidities, GI, Weight, Sleep, Fatigue

<p>Medical Comorbidities</p> <ul style="list-style-type: none"> Hypertension: Which medications does the patient tolerate? Immune disorders (lupus, Sjögren's syndrome, rheumatoid arthritis, etc) may increase severity of headache Bleeding disorders influence treatment Allergies/asthma affect therapy Miscellaneous medical conditions
<p>Neck Pain, Back Pain, Arthritis</p> <ul style="list-style-type: none"> Neck and/or back pain are common among headache patients Neck/back pain guide therapies (NSAIDs, muscle relaxants, pain preventives, PT, injections, etc) Osteoarthritis and rheumatoid arthritis influence medication decisions
<p>FM and TMD</p> <ul style="list-style-type: none"> Fibromyalgia: If present, how severe? What FM medications have worked, and has the patient had side effects? Any FM treatment other than medications? TMD: How severe? Is it bilateral? TMD: Has the patient had medications, injections, Botox, PT?
<p>GI Issues</p> <ul style="list-style-type: none"> Does the patient have reflux? History of ulcers? IBS is common among migraineurs. Does the patient have primarily diarrhea, constipation, or alternating? What medications have helped? Crohn's disease or lower GI disorders? History of bariatric surgery or bypass? Does the patient need or take a probiotic?
<p>Weight</p> <ul style="list-style-type: none"> Is weight gain an issue? How important are weight issues to the patient? Has the patient had weight gain from certain medications? Less common—is the person underweight, cannot keep weight on? Have medications helped with gaining weight?
<p>Sleep</p> <ul style="list-style-type: none"> Does the patient have insomnia, is it early, middle, or late insomnia? Which medications work for the person's insomnia? Have OTCs been effective? Has the patient had side effects? Sleep apnea: Does the person fit the profile? Periodic limb movements and restless leg syndrome also change treatment. Is there indication for a sleep study?
<p>Fatigue</p> <ul style="list-style-type: none"> How is the person's energy level? Is the person chronically tired? For how long? Is there a family history of chronic fatigue? Have any medications made fatigue worse or better? Does the patient wish to try medications for fatigue? Could the patient tolerate those medications?

receptor blockers (ARBs). When patients concurrently suffer with anxiety or depression, various antidepressants are utilized to manage the headache and mood disorder. We want to minimize medications, and treating 2 conditions with 1 medication is ideal.

The medication choices often depend upon comorbidities such as weight gain and fatigue. Weight often drives where we head with medicine.

Neck Pain, Back Pain, and Arthritis

These 3 conditions are commonly encountered in headache patients. We may utilize muscle relaxants and nonsteroidal anti-inflammatory drugs (NSAIDs) to manage pain from both conditions. Physical therapy, exercise, yoga, and Pilates are often recommended.

Sleep Disorders

Insomnia greatly influences treatment. Outside of recommending psychotherapy and sleep hygiene (setting consistent bedtime and waketime, etc), using a medication that helps both sleep and headaches is ideal. Side effects to OTC and prescription sleep medications may limit use. Assessing for sleep apnea is also important. Many chronic headache patients have sleep apnea, periodic limb movements, or restless legs syndrome.

GI Issues

Many patients with chronic headaches have a sensitive gastrointestinal (GI) system. IBS is common. If the patient has IBS-diarrhea (IBS-D), certain medications such as tricyclic antidepressants and verapamil may help both the headaches and diarrhea. With IBS-constipation (IBS-C), we want to avoid constipating medications. Other GI conditions (Crohn's disease, bypass surgery, etc) also influence our choice of medications.

Weight Gain

Weight issues greatly affect our choices. We may want to limit medications that have a potential for weight gain, or eliminate them altogether. Less commonly, patients who are underweight may benefit from certain headache medications that help increase their appetite and weight.

Fatigue

The most common comorbidity among chronic headache sufferers is fatigue. Patients do not want medications that exacerbate their tiredness. A few of our headache medications, particularly the stimulants, may help the condition. Chronic fatigue greatly affects quality of life. At times, we will treat the fatigue separately with medications that are

approved for sleep disorders and may not help the head pain (such as modafinil [Provigil] or armodafinil [Nuvigil]). With the presence of chronic fatigue, we will investigate other factors that may contribute, such as insomnia, medications that disrupt the sleep cycle, sleep hygiene, etc.

Table 6: Functioning, Social, Finances, Significant Other's Input

Knowing about the person's living and family situation may help. Whether he/she has a support system and friends is important. Job or school requirements may affect treatment. For instance, if a patient is an accountant, we may not want to utilize topiramate, which often causes thinking problems. If someone needs to be sharp early in the morning, limiting sedating medications at night is important.

The perspective of a family member often provides valuable information. Their input on the characteristics of the patient's headaches, functioning, moods, etc is helpful. This is particularly important when assessing for the mild end of the bipolar spectrum.

The patient's finances and insurance situation may influence treatment. We may avoid medications that the patient cannot afford. Utilizing discount sites and cards such as GoodRx.com is very helpful. If a patient cannot afford certain

Table 6: Functioning, Social, Finances, Significant Other's Input

<p>Functioning and Exercise</p> <ul style="list-style-type: none"> What is the person's level of functioning? Is the patient underfunctioning as an adult? Does the patient exercise? How much and what kind?
<p>Social Support System</p> <ul style="list-style-type: none"> How is the patient's friend and family support system? Is the patient isolated? Where does he/she live? Job (or school): What are the job requirements? Can the patient afford to be mildly "spacy" from medication? Will mild tiredness from medications in the morning affect the patient's job and/or functioning?
<p>Finances/Insurance</p> <ul style="list-style-type: none"> Can the patient afford certain treatments/medications (such as Botox)? Can the patient afford or have coverage for referrals (pain clinics, psychotherapy, physical therapy, etc)? Does the patient know about drug discount programs (GoodRx)? How is drug coverage? (If poor, use generics, GoodRx, etc)
<p>Significant Other or Family Input</p> <ul style="list-style-type: none"> What is the family perspective? How do they view how headaches affect the patient, his/her functioning, etc? What is the family input on depression/anxiety (if present)? Speaking with someone close to the patient is particularly vital for assessing the mild end of the bipolar spectrum.

Table 7: Your Gestalt, Treatment Recommendations, Follow-up Visits

<p>Your Gestalt</p> <ul style="list-style-type: none"> What does your gut say is the best approach with this patient? What medications do you feel will work? Which ones to stay away from? What non-medication approaches ("other villagers") should you emphasize?
<p>Medication Choices</p> <ul style="list-style-type: none"> After assessing all of the factors: What are the best medications to consider? Preventive and abortive choices: the "top 10 list" for that patient Which ones should absolutely not be used? Which medications are best avoided, if possible? How do you emphasize and list, in your chart, these choices (for the next visit or when the patient calls)? What non-medication approaches should be utilized, and which are most important?
<p>Return Visits: Preventives</p> <ul style="list-style-type: none"> If preventives are not working, or not working enough, consult the chart from previous visits to assess other good options for that patient Considerations include: <ol style="list-style-type: none"> Does the preventive work at all, and if so, how much? Side effects? Does it help comorbidities? How viable are the other preventive possibilities? Choices: <ol style="list-style-type: none"> Raise the dose Switch preventives Add another preventive
<p>Return Visits: Abortives</p> <ul style="list-style-type: none"> If abortives are not working, or not working enough, consult the chart from previous visits to assess other good options for that patient Considerations include: <ol style="list-style-type: none"> Is the abortive working well enough to continue? Side effects? What other choices are possible? Choices: <ol style="list-style-type: none"> Change dose or form of the abortive (for example: from tablet to nasal spray or injection) Add another medication to use concurrently with the abortive (such as an NSAID) Switch the abortive Add another abortive
<p>Return Visits: Nonpharmacological</p> <ul style="list-style-type: none"> At each visit, talk about moods, functioning, exercise If appropriate, discuss PT, psychotherapy, meditation, biofeedback, massage, injections (SPG/ONB/TPIs), appropriate referrals such as pain clinics, and other non-medication options

NSAID, nonsteroidal anti-inflammatory drugs; ONB, occipital nerve block; PT, physical therapy; SPG, sphenopalatine ganglion; TPI, trigger point injections

treatments (Botox, PT, etc), it may be best to go in another direction. In an ideal world, finances would not matter, but this is a consideration for many headache patients.

Table 7: Your Gestalt, Treatment Recommendations, Follow-up Visits

With each return visit, we want to assess whether the preventives we have prescribed have been effective. In addition, an evaluation of side effects is important. If efficacy is insufficient, we can push to increase the dose or discontinue the drug. If the preventive is not helpful for the headaches but is effective for comorbidities, it may be worthwhile to continue the medication. The logical medication choices should be listed in the chart from the previous visits.

As with the preventives, we need to evaluate efficacy and side effects of abortives and nonpharmacological treatments. If efficacy is lacking, we can change the form, change the dose, or discontinue the drug. With

most return visits, we want to reassess whether appropriate referrals are necessary. Exercise should always be discussed. It truly can take a village to raise a pain patient. ■

Author's Bio: *Lawrence Robbins, MD, recently published a new book, Advanced Headache Therapy: Outpatient Strategies. He was awarded the 2008 Janet Travell Clinical Pain Management Award by the American Academy of Pain Management. He has been chosen as one of America's Top Doctors every year since 2002. He has certificates in pain management, headache medicine, and psychopharmacology. He has previously published 3 headache books—one for patients Headache Help, one for physicians Management of Headache and Headache Medications, and an eBook Headache 2013-2014. Dr. Robbins has authored or co-authored 260 articles and abstracts. He has served his patients in his headache clinic since 1986. Dr. Robbins*

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