Headache Evaluation and Treatment by Primary Care Physicians in an Emergency Department in the Era of Triptans

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Background: Despite advances in treatment, patients with migraine have been underdiagnosed and undertreated.

Methods: Documentation of visits by patients with headache to an urgent care department staffed by primary care physicians was reviewed. Patients were also sent a brief headache screen, and those who replied were interviewed by telephone. “Repeaters” (patients who made 3 or more visits in 6 months) were excluded from chart review.

Results: Over 6 months, 518 patients made 1004 visits to the emergency department for primary headache complaints: 464 patients (90%) made 1 or 2 visits (total visits, 502). A review of 174 charts documenting a diagnosis of migraine found that (1) the need for prophylaxis was determined in only 40 (31%) of the patients who were not already undergoing prophylaxis and (2) treatment in the emergency department was migraine specific in 46 patients (26%) or otherwise appropriate in 45 (25%). A review of 90 charts documenting nonmigraine diagnoses found that 30 patients (33%) had adequate history documented to exclude migraine as the diagnosis. Eighty-six patients (17%) were interviewed. An emergency department diagnosis of migraine (n=59) corresponded to a final diagnosis of migraine with (n=21) or without (n=18) medication overuse or chronic daily headache and/or transformed migraine with (n=18) or without (n=2) medication overuse. Discharge diagnoses that were not migraine (n=27) had final diagnoses of migraine with (n=9) or without (n=9) medication overuse or chronic daily headache/transformed migraine with (n=7) or without (n=2) medication overuse.

Conclusions: In this emergency department population, many patients with migraine, chronic daily headache, or medication overuse are not accurately diagnosed. The need for prophylaxis is not usually assessed. Treatment is migraine specific in the minority of patients. Tension-type headache is rarely an accurate diagnosis in this emergency department population.


Annually, more than 10% of the population experiences at least 1 migraine headache.¹ Migraine has a major economic impact² and strongly affects an individual’s quality of life.³ Despite significant disability, many patients with migraine remain undiagnosed. In a population-based survey, only 41% of women and 29% of men with migraine had ever had their migraine diagnosed by a physician.⁴ Of patients with migraine who do present to a physician, only 45% to 51% receive a correct diagnosis.⁵

Patients with chronic daily headache (4%-5% of adults) and drug-rebound headache (1.5% of adults) may have severe disability as well.⁶,⁷ Drug-rebound headache is a daily headache sustained by the daily intake of analgesic agents or headache remedies. It is the most common reason for refractory headache. Drug-rebound headache has been coined an unrecognized epidemic.⁸

Although most (54%) migraineurs first consult their family physician or internist, the next most common site for medical care is an emergency department (ED), accounting for 16% of first presentations.⁹ Few articles have characterized the nature of care for patients with headache in the ED. In one study of a health maintenance organization over a 4-month period in 1991 and 1992, 152 patients made 323 ED visits for migraine: 36% of the patients made repeat visits, averaging 4.2 visits for migraine in the 4-month period.¹⁰ Eighty-six percent of patients were treated in the ED with narcotics; 6% were given a discharge prescription for a migraine-specific compound (ergot or isometheptene compound); and 3% were given a prescription for a mi-
PATIENTS AND METHODS

PATIENTS

Our medical group serves a large health maintenance organization with about 3 million members. The local facility serves a population of 160,000. The urgent care department (UCD) is situated next to the ED; patients presenting with headache would be seen in the UCD between 7 AM and 10 PM daily and in the ED after hours. Approximately 245 patients are seen in the UCD daily. The UCD is staffed by 5 full-time UCD physicians and a mixture of approximately 20 per-diem physicians and 50 full-time primary care physicians. All physicians are board certified or board eligible in internal medicine or family practice.

On a weekly basis, UCD notes were reviewed to identify patients who were discharged with a primary headache disorder (migraine, tension-type headache, or headache otherwise unspecified). Patients with associated febrile conditions or medical conditions that were likely to explain the headache (eg, sinus symptoms or uncontrolled hypertension) were excluded. Headaches due to recent trauma were excluded. Patients who were evaluated for “worrisome” headaches were also excluded. Emergency department (as opposed to UCD) notes were not reviewed because patients visiting the ED more commonly presented with worrisome headache syndromes.

Chart review was limited to patients with fewer than 3 visits to the ED in 6 months (nonrepeaters). Charts of patients with 3 or more visits to the ED in 6 months (repeaters) were not reviewed because these patients were usually well known to the ED staff, usually presented with a request for narcotic injection, and typically received little evaluation.

CHART REVIEW METHODS

For patients diagnosed as having migraine, we reviewed the charts if there was documentation of migraine prophylaxis, and if not, documentation of headache frequency. Medications considered to be migraine prophylaxis included tricyclic antidepressant, any β-blocker or calcium channel blocker, valproic acid, or gabapentin. Serotonin-specific reuptake inhibitors and other antidepressants were not considered migraine prophylactic agents. Appropriate reasons not to take prophylaxis included documented headache frequency of less than twice a month, documented lack of disability with headaches, failure with several prophylactic agents, or being followed by a neurologist.

For patients diagnosed as having migraine, we also checked if the prescribed treatment (both in the ED and at home) was migraine specific, and if not, if there was a documented reason not to use migraine-specific therapy. Migraine-specific treatment in the ED included any triptan or dihydroergotamine mesylate. Narcotics, parenteral nonsteroidal drugs (ketorolac tromethamine), and antiemetic agents were not considered migraine specific. Appropriate reasons for not using migraine-specific therapy included allergy to triptans; previous documented failure with such agents; unsuccessful use of triptan therapy for current headache episode; and contraindication to triptans because of a history of coronary artery disease or stroke, uncontrolled hypertension, or basilar or hemiplegic migraine. Relative contraindications were the presence of any 2 cardiac risk factors, including diabetes mellitus, hypertension, hyperlipidemia, smoking, age greater than 40 years for men or 50 years for women (or if no other risk factor was present, >50 years for men or >55 years for women). Migraine-specific treatment at home included ergotamine products, Midrin (Carnrick Laboratories Inc, Cedar Knolls, NJ), triptans, and dihydroergotamine. Butalbital products, nonsteroidal anti-inflammatory agents, and analgesic agents were not considered migraine specific.

For patients diagnosed as having headache other than migraine, we determined whether the history was adequate to exclude migraine based on criteria of the International Headache Society (Table 1). For all patients, we checked what physical examination was documented. Charts were reviewed for funduscopic and neurologic examination. An adequate neurologic examination was defined as any mention of cranial nerves and a motor response or deep tendon reflex examination.

After the first 3 months of chart review, protocol was revised to allow further investigation, and all patients were mailed a brief headache survey. Patients who returned the survey were contacted by telephone by a trained interviewer to confirm a clinical diagnosis. If the diagnosis did not conform to International Headache Society criteria for migraine, patients were diagnosed according to the revised criteria of Silberstein et al., as having transformed migraine (history of episodic migraine, now with daily headache); chronic tension-type headache; and either of these with or without medication overuse (use of analgesic agents or headache remedies >3/d/wk). The study design was approved by the institutional review board. Informed consent was not required.

RESULTS

Over 6 months, 518 patients made 1004 visits to the ED for primary headache complaints (Table 2): 426 patients (82%) made a single visit; 38 (7%) made 2 visits; and 54 (10%) made 3 or more visits (repeaters). Of all visits, 349 were to the UCD by nonrepeaters. From these 349 visits, 264 charts were available for review: 174 documented a discharge diagnosis of migraine, and 90 documented a nonmigraine headache diagnosis.

Eleven patients not previously identified as having migraine were diagnosed by UCD physicians. All other diagnoses of migraine were in patients who had identified themselves as having migraine. Overall, the need for prophylaxis was determined in only 40 patients (31%) who were not already undergoing prophylaxis. Two patients were started on prophylactic...
treatment. Evaluation of physical examinations found documentation of funduscopic examination in 37 migraineurs (27%) and an adequate neurologic examination in 7 (5%).

Table 3 summarizes the treatment of patients discharged with a diagnosis of migraine. Treatment in the ED was migraine specific for 46 patients (26%) or otherwise appropriate for 43 (25%). Migraine-specific treatment in the ED was highly associated with a written prescription of a migraine-specific therapy. For the patients who received migraine-specific care in the UCD (n = 46), 25 (54%) received migraine-specific prescriptions for home use, of which 20 were for triptans. Only 1 patient in the group not given migraine-specific care in the UCD received a triptan prescription.

The physician diagnoses of the 90 patients who were not diagnosed as having migraine are summarized in the tabulation below.

### Table 2. Distribution of Patients by Number of Visits to the Emergency Department During a 6-Month Period

<table>
<thead>
<tr>
<th>Visit No. Category</th>
<th>No. (%) of Patients</th>
<th>No. (%) of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Visit</td>
<td>426 (82)</td>
<td>426 (42)</td>
</tr>
<tr>
<td>2 Visits</td>
<td>38 (7)</td>
<td>76 (7)</td>
</tr>
<tr>
<td>&gt;2 Visits</td>
<td>54 (10)</td>
<td>502 (50)</td>
</tr>
<tr>
<td>Total</td>
<td>518 (100)</td>
<td>1004 (100)</td>
</tr>
</tbody>
</table>

*Percentages may not be exact because of rounding.
†Range, 3 to 50 visits per patient; mean, 9.2 visits per patient.

An adequate history to exclude migraine was documented in 30 (33%) records. Funduscopic examination was documented in 33 (37%) and an adequate neurologic examination in 8 (9%).

### Table 3. Treatment of Patients With Urgent Care Discharge Diagnosis of Migraine (n = 174)*

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Migraine-Specific</th>
<th>Not Migraine-Specific</th>
<th>Not Migraine-Specific, Appropriate</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care treatment</td>
<td>46 (26)</td>
<td>43 (25)</td>
<td>45 (26)</td>
<td>40 (23)</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>39 (22)</td>
<td>37 (21)</td>
<td>26 (15)</td>
<td>72 (41)</td>
</tr>
</tbody>
</table>

*All data represent number (percentage) of patients.

A brief headache survey was mailed to all 518 patients: 92 were returned, of which 86 responders were available for interview. Table 4 compares the UCD diagnoses with the clinical diagnoses made by a telephone interviewer. Tension-type headache without associated migraine or medication overuse was confirmed in only 1 patient.

**COMMENT**

Previous studies of ED care for headache did not distinguish patients with frequent ED visits for headache (labeled as migraine) from patients who were infrequent users of ED resources. Our population sample of ED nonrepeaters was selected because one would expect these patients to receive an adequate, even if brief, evaluation in the ED. Furthermore, since the medical staff is composed of family physicians and internists, the documented care may reflect the care of patients with primary headache outside an ED setting.
Failure to recognize drug-rebound headache is an important reason for treatment failure. There are no agreed-on standards for the evaluation of patients with migraine in the ED. The approach of one headache expert is given in Table 5. Findings from history review and physical examination are used to exclude worrisome causes of headache that may mimic migraine, and (juris)prudence would suggest a minimal evaluation of all patients with migraine. Although our UCD is staffed by primary care physicians, one cannot necessarily infer that the same level of care would occur in a primary care setting. Patients visit the ED for immediate relief rather than long-term management. However, for some patients the ED visit may be their only interaction with the health system for their headache disorder.

Our study of primary care physicians in an ED setting confirms previous studies showing that migraine is underdiagnosed and undertreated. Evaluation of these patients suggests that (1) most patients diagnosed as having migraine in the ED have transformed migraine; (2) most patients given nonmigraine diagnoses have migraine or transformed migraine; (3) medication overuse is common in ED patients with headache; (4) most ED patients with headache are not undergoing prophylaxis, even those who experience daily headache or consume analgesic agents daily; and (5) tension-type headache without medication overuse is rarely an accurate diagnosis in the ED. Physicians who work in urgent care settings have an important opportunity to improve the care of patients with primary headache disorders.

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REFERENCES


