Comment on ''Headache as a reason for consultation: The primary care perspective''☆

Comentario sobre «Cefalea como motivo de consulta: la visión desde atención primaria»

Dear Editor:

We read with great interest the article by López-Bravo et al.[1] entitled ''Headache as a reason for consultation: the primary care perspective,'' which describes headache as an underdiagnosed and undertreated condition, probably due to the lack of training of primary care (PC) physicians. We would like to thank the authors for their valuable contribution, with which we agree, and make some comments.

One of the indicators used to assess the impact of a clinical entity is the healthcare demand associated with the disease. Headache represents one of the main reasons for neurological consultation in PC.[2] Among patients consulting PC physicians due to headache, more than 90% present some type of primary headache. Although the prevalence of tension-type headache is higher than that of migraine, the number of PC consultations due to migraine is clearly higher than those motivated by tension-type headache. Regarding specialist neurology consultations, several studies confirm that headache is the main reason for referral from PC.[3] This suggests that it is essential for PC physicians to be equipped with the tools and knowledge to promptly establish a diagnosis of and treatment for headache, with a view to avoiding referrals to specialised units where possible. Otherwise, specialists would have to attend a high number of patients, leading to longer waiting times and potential negative consequences.

We have identified studies in the literature reporting similar trends in such other countries as Saudi Arabia[4] and Brazil,[5] with results in line with those obtained in Spain. This supports the idea that, despite the sociocultural differences between the 3 countries, the approach to the assessment of headache and chronic migraine presents certain shortcomings. Despite physicians' great interest in neurological care, several factors, such as their clinical experience and specialty (other than neurology), may negatively impact their ability to adequately perform a neurological examination to establish the diagnosis and treatment of migraine and headache. This may be due to the fact that less experienced physicians are less confident when assessing patients[4,5]; furthermore, some physicians whose specialties do not involve direct contact with the emergency or the neurology departments have been reported to present certain limitations in the diagnosis of neurological patients.[5]

All 3 studies found that a significant percentage of physicians have insufficient knowledge of the diagnostic criteria presented in the International Classification of Headache Disorders, version 3 (ICHD-3), partly because the definitions, having been drafted for neurologists, may be confusing. A controlled interventional study performed in Estonia reported a degree of improvement in the performance of PC physicians after the implementation of a training programme. This may result in cost savings in the long term (due to a reduction in the number of misdiagnoses and unnecessary referrals to specialists and selection of an appropriate treatment) and, most importantly, a positive impact on care quality.[6]

Neurologists are well aware that diagnosis and indication of an appropriate treatment for headache requires detailed examination; therefore, some alternatives should be suggested to improve the medical understanding of this condition. Without a doubt, the causes of underdiagnosis in primary headache may be diverse. Tools to avoid this include the ICHD-3. One research group performed an analysis of correct diagnoses of headache, which reported that ''Of the 105 GPs who were consulted, 46 (44%) diagnosed migraine correctly, 41 (39%) diagnosed the patient as tension-type headache, 17 (16%) as 'mixed' headache and one GP was unable to diagnose the patient.''[3] This demonstrates a widespread lack of knowledge of the disease and the lack of follow-up. Misdiagnosis leads to inefficient medical treatment. One measure to be considered is the standardisation of diagnostic methods as a response to a lack of evaluation. This phenomenon should be reviewed to establish a correct diagnosis and improve the patient's quality of life.

Despite healthcare professionals' considerable interest in the study of headache, most clinicians lack knowledge regarding the condition and its variants. To address this, López et al.[1] reported interest in an online communication system as a means of medical training. In this regard, we should underscore the study ''Email in a dedicated headache clinic: experience gained over a five-year period,'' which described the use of e-mail for communication between PC consultations and headache clinics.[7] The authors analysed the e-mails sent from rural and urban health centres to the headache clinic of the Neurology Department at Hospital Clínico Universitario de Valladolid. The aim of the e-mails was to provide information on patients previously attended, to make training consultations on headache, and for healthcare professionals to report on their own headache. The study concluded that this means of communication was important in increasing safety and the satisfaction of patients and healthcare professionals.[7] In Colombia, this practice would be beneficial, as studies conducted in the Department of Santander reported a prevalence of migraine of 13.7%, predominantly affecting women.[8] Implementing this strategy may increase patients' confidence in their diagnosis and medical treatment, in addition to virtually connecting communities located far from specialist clinics.

We agree that strategies should be implemented to help PC physicians to improve the analysis and interpretation of neurological examinations in order to indicate effective treatments. Furthermore, the use of electronic tools should be adapted to improve communication between headache clinics and PC centres, as a key step in achieving the proposed objective.

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