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Neglected headache: Ignorance, arrogance or insouciance?

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Headache is one of the most frequent medical complaints. Almost everybody has experienced it, 50–80% of adults from all countries report it as a recurring nuisance, 10–20% are at least sometimes disabled by it, and up to 3% bear it – with varying levels of difficulty – on more days than not (1). The consequences, not only pain but also disability, financial losses and impaired quality of life, are well known to all who work in the field. We write about them constantly. Over a decade ago, the World Health Organization (WHO) ranked migraine alone as the nineteenth highest cause of disability worldwide (2), and they have recognized it since as a public-health priority (3,4). Headache is the most frequent cause of consultation in both primary care and neurological practice, and, on top of this, headache promotes many visits to internists, ENT specialists, ophthalmologists, dentists, orthopaedic surgeons, psychologists and the proponents of a wide variety of complementary and alternative medical practices (4). Headache is far from unknown as a presenting symptom in emergency departments.

So one would assume that a disorder so highly prevalent, and with such adverse consequences for people and the societies to which they belong, would be considered an important medical problem by people affected by them, by health-care providers and by health policy-makers everywhere.

In Germany, Radtke and colleagues, reporting a study of 7431 adults (5), tell a quite different story: that ''self-awareness and medical recognition of migraine are low''. On the one hand, only 70% of people whose headaches met ICHD-II criteria for migraine recognized them as such; on the other, fewer than two-thirds of those who consulted a physician in the previous year, for headache, reported that migraine had been identified. Among apparent misdiagnoses, tension-type headache was most common (56%) but, depressingly, 9% were labelled with the non-existent disorder of ''sinus headache''.

How robust are these findings? The study was part of a survey covering a wide range of health-related issues; it was large and population-based (6). Participants were randomly selected, and diagnosed by modified ICHD-II criteria using computer-assisted telephone interviews. The estimated 1-year prevalence of migraine was 10.6% (15.6% in women and 5.3% in men), lower than in most surveys of Western Europe (7). If cases were missed, as seems likely, the reason lay probably in the screening question, which allowed the enquiry to proceed only when severe headache was reported in the previous year (not all migraine headaches are severe). If this led to ascertainment bias, it was towards those worse affected, and therefore consultation rates might be relatively high. Yet, only 41% of identified cases had made their way to a doctor.

Radtke and colleagues did not report participation rate. Selection bias is likely in all telephone surveys, and enquiry over the past year is at the mercy of recall bias. Nevertheless, the pertinent finding of unconcern is entirely in line with others from elsewhere. The WHO's survey of 102 countries (4) ''illuminates the worldwide neglect of a major public-health problem, and reveals the inadequacies of responses to it in countries *throughout the world*'' (our emphasis). Where economic constraints and social disparities mean that medical care is not freely accessible, this may, to some extent, be expected. (This is not to say that unconcern is justified: for example, in countries of the former Soviet Union, including Russia and Georgia, medical care for people with headache is

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unstructured, patchy and inefficient, while headache on ≥15 days/month affects, alarmingly, 10.4% (8) and 7.6% (9) of adults respectively.) But why, in wealthy Germany, with free access to medical care and almost any kind of necessary treatment, do people suffering from migraine not seek care, and why are they apparently poorly served when they do? Germany is not unique in this: "What is it about headache?" was the *cri de Coeur* of the editor of the journal *Headache*, reflecting recently on the lack of recognition and underfunding of headache in the United States of America (10).

Is it ignorance? Radtke and colleagues noted that people with lower levels of education were less likely to be diagnosed and effectively treated. In another study in Germany, one fifth of first-generation Turkish immigrants reported headache on ≥15 days/month, most of them overusing acute headache medications, but none had ever contacted a doctor for headache (11). So are people with headache largely to blame? Failure to consult is a certain barrier to effective care, but the reasons for it need to be examined. In resource-poor Georgia, people with headache are keen to receive help, and even here are not deterred by unwillingness to pay for it (12). But many are unaware of the possibility of effective treatment (9). Here and elsewhere, when the effort to consult is made, incorrect diagnosis – and presumably incorrect treatment – not only lead to poor outcomes but also discourage those who would seek care.

Is it arrogance? Doctors, especially general practitioners, do not see headache as medically important, or deserving, and do not spend the time needed to diagnose it, educate patients about it, give advice, initiate appropriate treatment, and follow up to ensure best outcomes. Are they to blame? Again, the reasons require examination. The ineluctable truth underlying these failures is that significant resources are required for all of this, for large numbers of needy patients, and they simply are not allocated. It boils down to a gross priority mismatch, for which insouciant society has only itself to blame.

What needs to be done? The WHO has shown the way (4), if we will take it. Health-care for headache disorders must be improved. Many effective drugs exist for headache disorders, but countries in all income categories identify restrictions to access to them. Yes, resources are limited, but the WHO's *Atlas* reveals widespread wastage (4): for example, high usage of investigations is commonplace, despite most headache disorders not requiring them for diagnosis or assessment. Substantial reductions are manifestly possible, and would release resources to underfunded treatments. Headache services must be organized, if they are to be delivered efficiently and equitably to the very large numbers of people who stand to benefit from them. Most crucially, however, lack of education is held aloft as the key impediment to good headache management. In the WHO's survey, better professional education, recommended by 75% of responding countries, ranked far above all other proposals for change (4). Health-care providers need better knowledge of how to diagnose and treat the small range of headache disorders that affect large numbers of people – knowledge which will avoid wastage, improve usage of available treatments, produce better outcomes, recover lost productivity and *reduce* overall costs. Importantly, as many people with headache will inevitably continue to self-treat, educating *them* is also of public-health value. One focus, quite evidently, should be the avoidance of medication overuse. Finally, for all of these, there is need for political recognition that the problem exists, that it demands remedial action (13), and that the right action would be cost-saving (4). Insouciance towards headache among those responsible for health-care planning and provision, whether born of ignorance or arrogance, is no longer to be tolerated.

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