Response Report for Review and Comment – January 2013
Diagnosis and Treatment of Headache Guideline

Member Groups Requesting Changes:

Marshfield Clinic
Mayo Clinic

Member Groups that Reviewed the Guideline, No Changes Requested:

Lakeview Clinic

Member Groups that Responded but the Guideline Does Not Pertain to Practice:

None

Sponsoring Health Plans Requesting Changes:

Medica Health Plan

Sponsoring Health Plans that Reviewed the Guideline, No Changes Requested:

HealthPartners Health Plan

GENERAL COMMENTS:

1) This is a long, confusing, difficult document to use. Future iterations of this documents should be cut by 90%, references from the 1970s, 80s and 90s should be deleted and updated. Are there metrics demonstrating that people find this useful? An articulate author could convey all the useful information in this document in less than 10 pages (from the current 96). (Mayo Clinic)

   Thank you for your comments. Although the document may seem long, the ICSI guidelines are written with the algorithms as the basis of the document. The annotations that correspond to algorithms are there to provide more information to the reader. We recognize that some of the supporting literature is old, however, the research hasn't changed.

2) The most recent American Academy of Neurology practice parameter (published April 25, 2012) should be incorporated, even though their references are only current to 2009. (Mayo Clinic)

   Thank you for your comment. We have reviewed the American Academy of Neurology's documents and have included information on petasites and sumatriptan nasal spray.

3) American Academy of Neurology has released several guidelines (see attached) (Marshfield Clinic)

Thank you for your comment. We have reviewed the American Academy of Neurology's documents and have included information on petasites and sumatriptan nasal spray.

MEDICAL CONTENT:

4) The use of Botox, which is a major advance in the field, is not referenced. (Mayo Clinic)

*Thank you for your comment. Botox is addressed within the context of Annotation *123 as a therapy option. This document is for the primary clinician, therefore, further details on the use of this is not included as this is left to the specialist utilizing the therapy.*

5) The AAN parameter states there is no class A evidence for the use of verapamil in migraine, at odds with what is stated in this current document, which utilizes a 1983 article as its primary reference. The challenge is that what were considered high quality studies 30-40 years ago, would now be classified as level B or Level C evidence in 2012. (Child and adolescent Neurology, Mayo Clinic and Pediatric Neurology, Mayo Clinic)

Thank you for your comment. The 1983 article comparing verapamil to placebo for migraine prophylaxis is a reasonably well-conducted randomized controlled trial (RCT). The American Academy of Neurology will not give a Grade A rating based on a single RCT. We do not follow that policy. Based on GRADE ratings, this is a high quality study.

6) Algorithm Box 23, pg 29: Please consider the recommendations outlined in the Report of the Quality Standards Subcommittee of the American Academy of Neurology with regard to performing diagnostic testing. References: Stephen D. Silberstein, MD, FACP, for the US Headache Consortium. Neurology 2000. 55:754-762. (Marshfield Clinic)

Thank you for your comment. We have added some material from the Silberstein paper about neurologic signs or symptoms that increase the risk of an abnormal finding on neuroimaging, We have chosen not to adopt the Grade C recommendations and believe we have captured the Grade B recommendation in that article.

7) Algorithm Box #34: Working with a health coach can support an individual who is making lifestyle changes. References: Patients with Complex Chronic Diseases: Perspectives on Supporting Self-Management, Sevick et. Al J Gen Intern Med 22(Suppl3):438-44. Patient Engagement and Coaching for Health: The PEACH study, Young et. Al, BMC Family Practice 2007, 8:20 vol: 10.1186/471-2296-8-20. (Medica Health Plans)

Thank you for your comment. The work group has reviewed this and has determined that the evidence is not strong in supporting the effectiveness of coaching related to headache management.

8) Algorithm Box #46, p. 32: Please add breast-feeding and allergy to the list of conditions. (Marshfield Clinic)

Thank you for your comment. Breast-feeding has been added to the list. We have not listed allergy to the list since allergy to something is always a contraindication.

9) Algorithm Box #: 78, p. 5: Please add generic name for Depakote, divalproex sodium (Marshfield Clinic)

Thank you for your comment. This has been added.

10) Algorithm Box #: 87, p. 6: Replace "cc" with "ml" after 1000. (Marshfield Clinic)

Thank you for the comment. The correction has been made.

11) Algorithm Box # 84, p6 and all boxes in the algorithm that refer to IV dosing of DHE and Appendix A, p. 79: The max dose of IV administration DHE is 2 mg/24 hours. References: Clinical Pharmacology Drug Information Handbook 2010-2011 Micromedex. (Marshfield Clinic)

Thank you for your comments. We have changed the dosing to 2 mg/24 hours. In addition, we have eliminated the remainder of this algorithm as there are other up-to-date resources for determining appropriate DHE administration.

12) Algorithm Box #85, p. 36: "Intravenous" is misspelled. (Marshfield Clinic)

Thank you for pointing out this error, the correction has been made.

13) Algorithm Box Starting with box#85: DHE Algorithm: metocolpramide is listed throughout the algorithm as the antiemetic. Other antiemetic agents, e.g. ondansetron (Zofran) may be used in place of metoclopramide. Consider keeping more generic. (Marshfield Clinic)

Thank you for your comment. Metocolpramide has prokinetic qualities and is the most often used medication. There is no evidence to suggest other drugs that are used as antiemetics work as well.

14) Algorithm Box # 99, pg. 6: Avoid the use of trailing zero, and the max does for IV administration of DHE is 2 mg/24 hours.

Thank you for your comments. We have changed the dosing to 2 mg/24 hours. In addition, we have eliminated the remainder of this algorithm, as there are other up-to-date resources for determining appropriate DHE administration.

15) Algorithm Box # 111, p. 39: Estrogen-containing contraceptives, 3rd paragraph: 1. Drospirenone: Consider adding information about the increased incidence of a potentially fatal, although rare, venous thromboembolism compared with other progestin containing produces (e.g., levonorgestrel)." 2. "Drospirenone" is misspelled. (Marshfield Clinic)

Thank you for your comments. Although all estrogen-containing products have clotting risk, the information related to drospirenone FDA alert has been included. The spelling error has been corrected.

16) Algorithm Box#129, pg. 9: Indent IUD Barrier Method under Non-hormonal and add "non-hormonal" to IUD, because there are medication containing IUD's. (Marshfield Clinic)

Thank you for your comments. Since the medicated IUDs contain progestin, we have modified the box and have placed "IUD" under progestin methods.

17) Table, p. 34: The table seems out of place. Would it be more appropriate in an appendix? (Marshfield Clinic)

Thank you for your comment. We have moved this table to Appendix A.

18) Table, p. 42: "nortriptyline" is misspelled. (Marshfield Clinic)

Thank you for pointing out this error, the correction has been made.

19) Appendix A, p. 79: Consider removing the dose detail information because it is not complete, Prescribers should utilize a drug reference for updated information on dose, dilution, and administration. (Marshfield Clinic)

Thank you for your comment. We do agree that for common drugs, prescribers should utilize current drug references, however, we have opted to include the current drugs listed as these are drugs that are not easily referenced.

20) Appendix A, p. 79: If keeping drug information DHE max dose of IM and IV differs. Max dose of IV is 2 mg/24 hours. References: Clinical Pharmacology Drug Information Handbook 2010-2011 Micromedex (Marshfield Clinic)

Thank you for your comment. We have modified the dosing information.

21) Appendix A, p. 79: Remove trailing zero in DHE dose. (Marshfield Clinic)

Thank you for pointing this out, the correction has been made.

22) Appendix A. p. 79: Chlorpromazine information on dilution and administration is confusing. Consider revising if keeping this appendix. Reference: Clinical Pharmacology states Intravenous dosage (for severe cases where oral or rectal preparations cannot be administered): Adults and Adolescents: 0.1 mg/kg IV every 15 minutes, up to 3 doses, has been recommended. If the IV route is used, follow manufacturer directions for dosage dilution to 1 mg/ml with NS and administer dose via IV infusion at a rate no faster than 1 mg/min. Keep patient recumbent for the duration of the infusion and for 30 minutes after completion of the dose. (Marshfield Clinic)

Thank you for your comment. We have updated the dosing information for Chlorpromazine as indicated.

PRIORITY AIMS AND SUGGESTED MEASURES:

None

SUPPORT FOR IMPLEMENTATION:

None