

# Getting the best out of your consultation

## Migraine Association Ireland 2022

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1. General advice
2. How does your doctor approach the consultation?
3. How to prepare for the consultation
4. Useful resources
5. Q + A – anything on headache disorders

# General advice

- Be prepared
- Don't get angry with the traffic, the parking, the wait in reception, receptionist or nurse – it may not seem like it but everyone is trying to help - often people are working under a lot of pressure –
- Be friendly and polite – you will get the best out of your doctor if you create a good rapport
- Try not to get flustered or angry
- Relax – we want to help you so do not be frightened or anxious

# General advice

- Know what you need to tell the doctor
- Try and answer the specific question
- Keep to the point - don't wander off track
- You are the detective's assistant – guide them – they will be asking questions to help them make or break any of their initial diagnostic considerations
- Don't feel afraid to mention something important if you have not been given the opportunity to tell it

# General advice

## At the end of the consultation:

- Do not be afraid to ask questions
- Ask for a copy of the clinic letter to be sent to you so you can follow the plan
- Be aware GP's always say they have not received our letters (they are usually somewhere in the system to be loaded online!)
- Ask the diagnosis if it is not clear to you
- Ask for a clear plan of management if it is not clear
- Check what you need to do – you will often have to go and specifically ask a GP to institute the actions from a hospital clinic letter.

# Realistic expectations

- Have *realistic* expectations from you you want to achieve from your consultation
  - Diagnosis
  - Reassurance
  - Investigations (eg scans)
  - Treatment
  - Support
  - Advice

# You may have theories as to cause ? Best to let doctor know or not

## Problems:

- Many doctors will give same label that patients suggest (which may be wrong)
- Doctors are like detectives and want to be clever – they want to be clever and may feel it is their role to diagnose you, not yours! Sometimes they will recoil from a patient's suggestion and even suggest the opposite!
- Be careful about using the term “research” – it can put doctors back up when patients use this term in relation to google or social media – we use term research to reflect peer-reviewed scientific publications

# The awkward doctor

Rather than getting upset (where you may be the one to lose out), try to be clever and try to understand why some doctors appear to you as:

- Arrogant
- Condescending
- Short
- Irritable
- Appears uncaring
- Incompetent
- Poor communication

If they are, try and work out how to “play” them to get the best for you – try not to get upset – not everyone in medicine has good doctor-patient skills and some of the cleverest clinicians will have their own issues (eg a lot of neurologists are probably somewhat autistic)

If a doctor is flustered / irritable, it is often because they

- don't understand your condition
- Have too little time allocated to delve into the complexities of your condition (or follow convoluted accounts)
  - GP has approx. 8 minutes per consult
  - Hospital doctor has approx. 20—30 minutes for new patient, 10-15 minutes for a follow up

The time includes

- reading your notes
- Looking at your test results and/or scans
- Assessing your condition
- Arranging any tests
- Writing any letters required

# Be aware of and use transference

The feelings you experience in a consultation are what the other person feels

- If you feel anxious with someone, it is likely they feel anxious
- If I feel worn out after a consult, then that is likely what the patient experiences
- If I feel angry in a consult, it is likely my patient has anger or is frightened by what is happening to them

Think about how you feel in the consultation and adjust to it or use it to interpret why the doctor made you feel that way

e.g. the doctor may make you feel hopeless and helpless as they don't have a good understanding of what is wrong with you or a longwinded history has overwhelmed them and they do not know where to start

If your symptoms are not in their textbook, they may label you as psychological or functional neurological disorder

We as doctors are limited by our:

1. Textbook knowledge
2. Clinical experience

If your symptoms do not readily fit the above there may be a tendency for doctors to somewhat dismissive or label as psychological

Be wary of such a label, particularly if you have headache disorder

Many patients with headache disorder have illusory symptoms or signs and many people find such problems disappear when treated effectively for their headache disorder

# How does your doctor approach the consultation?

1. Looks at referral letter – makes list of most important diagnoses
  - Conditions that kill
  - Conditions that will disable
  - Conditions that are highly treatable
2. Throughout consult – questions to make or break most likely diagnoses
3. Place in context of past medical history
4. Identify factors that influence diagnosis or management
5. Look for opportunities of overall health improvement
6. 90% of neurological diagnoses from history, <5% each from examination or investigations

# How does your doctor approach the consultation?

7. Consider differential diagnosis
8. Communicate diagnostic likelihood
9. Consider investigations
10. Communicate plan of management to GP and patient
  - Patient actions
  - GP actions – eg prescription or monitoring
  - Specialist actions – eg tests
11. Signpost to support groups

# How to approach headache – most useful discriminators

1. **Mode of onset** – Episodic or New Daily Persistent?
2. **Site** of headache - Side-locked or side-predominant? Within Trigeminal distribution or beyond?
3. **Behaviour** - What do you do when it is most severe?

Wounded lamb (migraine)



vs. Wounded lion (TAC)



4. **Attack** – Duration and Timing
5. **Alcohol triggering** early vs late
6. **Cranial autonomic features** – severe or not
7. **Discrete cutaneous triggers?**
8. **? Least useful discriminators** - presence of migrainous features – stimulus sensitivity, nausea, vomiting, exacerbation by movement etc.
9. CCHAF days and painkiller / caffeine consumption

# Differential diagnosis of primary headache

|                                                 | Frequency                         | Duration                 | Laterality<br><i>Severity</i>                     | Migrainous<br>"features"<br>(aura,<br>photophobia,<br>nausea etc) | Autonomic | Behaviour /<br>characteristic<br>features                    |
|-------------------------------------------------|-----------------------------------|--------------------------|---------------------------------------------------|-------------------------------------------------------------------|-----------|--------------------------------------------------------------|
| <b>Tension-type headache</b>                    | Daily to monthly                  | hrs - months             | <b>Bilateral</b><br><b>Never severe</b>           | NEVER<br><b>TTH is featureless</b>                                | NEVER     | <b>Never limits activity</b>                                 |
| <b>Migraine</b>                                 | Daily to monthly                  | > 4 hours to days        | Unilateral or bilateral<br><i>+/- severe</i>      | Yes                                                               | +         | <b>Stay flat and still</b>                                   |
| <b>Hemicrania Continua*</b>                     | Continuous                        | Continuous               | <b>Sidelocked</b><br><i>+/- severe</i>            | +/-                                                               | +++       | <b>Agitation +/-</b>                                         |
| <b>Cluster headache*</b>                        | Clusters or chronic:<br>1-4 / day | < 4hours<br>~ 15-40 mins | <b>Sidelocked</b><br><i>Usually severe</i><br>+++ | +/-                                                               | +++       | <b>Restless agitation+++</b><br><b>EG pacing, punch head</b> |
| <b>Paroxysmal Hemicrania*</b>                   | 10 – 40 / day                     | ~ 10-20 mins             | <b>Sidelocked</b><br><i>Usually severe</i><br>+++ | +/-                                                               | +++       | <b>Agitation ++</b>                                          |
| <b>SUNCT*</b><br><b>* MRI / MRA recommended</b> | 60 – 400 / day                    | ~ < 2 minutes            | <b>Sidelocked</b><br><i>Severe</i> +++            | +/-                                                               | ++        | <b>V1 distribution</b><br><br><b>No refractory period</b>    |

# Migraine the disorder

vs

# Migraine Biology

Genetic predisposition

Spectrum: few genes ↔ many

Does everyone have a tendency to migraine – if so, how much?

The presence of migrainous features does **not** mean **it is** migraine

Everyone with migraine “may wear a migraine hat”

Patients with cluster headache / TAC / may have:

- Aura
- Photophobia, phonophobia, osmophobia
- Nausea, Vomiting

# *What happens in migraine may happen in other headache disorders if migraine predisposition*

## **Amplification**

### **“Stimulus sensitivity”**

Throbbing / pounding

Pain

Tenderness / allodynia

Sensitivity to:

Movement

Noise (photophobia)

Light (phonophobia)

Smell (osmophobia)

Vestibular (dizziness)

## **Autonomic**

Nausea + vomiting

Diarrhoea, increased urine

Pallor, flushing

Eye –red, runny, drooped

Blocked, runny nose

Ear fullness

Bruising, swelling

## **Brain dysfunction**

Aura

Mood change

Confusion / memory

Fatigue

Restless legs

# NHS Vanguard Comprehensive Migraine Guide

Dr Nicholas Silver

[www.bit.ly/migrainebooklet](http://www.bit.ly/migrainebooklet)

# How do I approach Treatment Options

## Optimise current situation

- lifestyle, medication / caffeine overuse
- Optimise sleep function

## Active preventative Treatments

**Oral Preventative Drugs**

Vs.

**Handheld stimulators**

Vs.

**Local Injections**

Vs.

**Systemic Injections**

**(CGRP Monoclonal Abs)**

**Efficacy**  
**Safety**  
**Tolerability**  
**Practicality**  
**Compliance**  
**Teratogenicity**  
**Cost**  
**NHS resources**

# How to prepare for the consultation

## Past medical history

- Significant past and current **medical** and **surgical** and **psychiatric** conditions

## Current list of main symptoms in order of severity – keep it simple

1. Headache
2. Fatigue
3. Poor memory
4. Twitching legs
5. ....

# How to prepare for the consultation

Prepare a ***brief*** timeline for how condition **started**:

? Persistent from onset, vs

? Intermittent from onset – as episodes (with 100% normality between)

***Brief*** outline of how your condition **developed**

**Current headache frequency (days per month) – add up to 30**

- Crystal clear headache free days – “100% normal”
- Mild headache days – “non-intrusive”
- Moderate headache days – “bad but does not stop you functioning fully”
- Severe headache days – “bad enough to stop you functioning for part of day”

Dr Silver Walton Centre Headache Diary - <https://www.thewaltoncentre.nhs.uk/departments-and-services/headache-service/415522>

# How to prepare for the consultation

## Headache details:

- Site – head, face, neck, elsewhere
- ? Strictly unilateral; ? Always worse on 1 side, ? Swaps sides
- Background intensity (0-10/10)
- Intensity of worst headaches (0-10/10)
- Duration and timing of worst attacks
- Nature – eg pressure, exploding, sudden stabs, electric shocks, burning
- Effect of posture
- Behaviour – e.g. flat / still **vs** restless / agitated
- Nausea, vomiting, sensitivity – light, noise, smell

# How to prepare for the consultation

- Cranial autonomic disturbance
  - Eye – red, runny, droopy, puffy
  - Nose – stuffy, runny
  - Face – flushed, sweaty
  - Ears – feeling of fullness, tinnitus
- Non- headache symptoms
  - Fatigue, vertigo, dissociation, mood change, restless legs, insomnia etc.
- Other important symptoms

# How to prepare for the consultation

- Previous treatments – **list each medication**
  - Acute attack treatments (eg painkillers, triptans)
    - Dose used
    - Reliability
    - Side effects
    - Effectiveness – how quick to work
  - Preventatives
    - Whether had stopped or limited acute treatments and caffeine during trial
    - Highest dose reached – for how long
    - How long stayed on “maximum, fully tolerated dose”
    - Side effects
    - Effectiveness (0 – 100% - from 0% = no benefit up to 100% = cured)

# How to prepare for the consultation

- **Current treatments**

- Acute attack for headache – painkillers, opiates, NSAIDs
  - List each one
  - For each one - number of tablets taken in average week
- Oral nasal decongestants
- Preventatives
  - Dose
  - Side effects

- **Caffeine consumption per week**

- Tea, green tea
- Coffee
- Cola, Dr Pepper
- Energy drinks
- WKD
- Chocolate – eating / drinking

# Useful resources

OUCH UK

<https://ouchuk.org>

The Migraine Trust

[www.migrainetrust.org](http://www.migrainetrust.org)

NHS Vanguard Comprehensive Migraine Guide

[www.bit.ly/migrainebooklet](http://www.bit.ly/migrainebooklet)

# Useful information

## The Walton Centre – headache pathway and downloads

<https://www.thewaltoncentre.nhs.uk/Downloads/Information%20for%20healthcare%20professionals/Headache%20pathway%20rev%20%20W%20Chesh%20APC%20-%20%20Pan%20Mersey%20rev%202020%20clarified%2012.20%20B.pdf>

<https://www.thewaltoncentre.nhs.uk/departments-and-services/headache-service/415522>

## Migraine and Disability

<https://thejournalofheadacheandpain.biomedcentral.com/articles/10.1186/s10194-020-01208-0>

<https://link.springer.com/article/10.1186/s10194-018-0846-2>

<https://migrainetrust.org/wp-content/uploads/2021/09/TMT-Welfare-Benefits-Factsheet-2021-AWweb.pdf>

# Q+A

## Dr Silver remote video private consultations

Spire Cheshire Hospital 0044 (0) 1925 265 000

<https://www.spirehealthcare.com/spire-cheshire-hospital/enquire/>

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