ICHD 3 Beta on Field Trial - Some Pitfalls and Suggestions for Improvement

Received: April 29, 2016; Accepted: April 30, 2016; Published: May 08, 2016

Editorial

Disease classifications are very important when clear biomarkers are not easily available. Attempts at classification of headache disorders date back to first century A.D but it was as late as 1962 when an ad hoc committee of the National Institute of health introduced the first classification of headache. The International Headache society published its first classification in 1988 and its second edition in 2004 [1]. It is not surprising that some aspects of these two documents generated debate among experts and researchers all over the world. ICD 11 (International classification of diseases) and ICHD 3 beta [2] are in the phase of field trials now. This test period is for identification and correction of mistakes and to enable a broad input from headache researchers from different regions of the world. After studying ICHD 3 Beta closely for nearly three years and discussing, teaching, researching and presenting ICHD 1 & 2 for many years, I would like to focus on some inconsistencies and to propose some modifications to certain diagnostic criteria based on published research evidence.

In countries like India more than 90% of the headache patients are managed by either non neurologists or Complementary and alternative practitioners like Ayurveda, Homeopathy, Acupuncture etc. Nearly 90% of the recurrent headaches seen in any outpatient clinic are either migraine or tension. Group Acupuncture etc. Nearly 90% of the recurrent headaches seen in any outpatient clinic are either migraine or tension. Group Acupuncture etc. Nearly 90% of the recurrent headaches seen in any outpatient clinic are either migraine or tension. Group 1 & 2 (infrequent episodic tension type headaches - 2.1), it is stated that at least 10 episodes of headache occurring on <1 day per month on average (<12 days/year) and fulfilling criteria B-D, and criterion B is LASTING FROM 30 MIN TO 7 DAYS. These statements are really confusing/not very helpful when trying to diagnose tension type headaches. This is more so when one tries to apply Paediatric migraine diagnostic recommendations (8/10 overlaps). In Gr 1 & 2, Criterion D/E (not better accounted for by another ICHD diagnostic criterion) makes everything PROBABLE (missing one criterion) and no way can basic practitioners and other clinicians master all the pages in ICHD 3 beta. This is the feedback I get from thousands of practitioners who manage headaches in India and who see 100-300 patients a day , out of which nearly 10 to 20% with recurrent headache in India. InGr 1 & 2, Criterion D/E (not better accounted for by another ICHD diagnostic criterion) makes everything PROBABLE (missing one criterion) and no way can basic practitioners and other clinicians master all the pages in ICHD 3 beta. This is the feedback I get from thousands of practitioners who manage headaches in India and who see 100-300 patients a day , out of which nearly 10 to 20% with recurrent headache in India. In difficult clinical scenario, ICHD 3 Beta recommends to consider all other available information to differentiate between mild migraine episodes and episodic tension type headaches but no guidance on this evidence/available information. My 26 years clinical research experience [3-9] shows that family history of migraine/migraine synonyms and known/common migraine triggers are very helpful evidence in differentiating both. It is well known that some migraine triggers like hunger and sleep disturbances can precipitate tension type headaches but activity getting affected (in migraine) can easily distinguish between the two. Migraineurs get Premonitory symptoms more than auras and auras without headache are diagnostic of migraine, why not a premonitory symptom in the diagnostic features/considered diagnostic? Another disappointing fact is that there is no description about post dromal symptoms in this beta version. In Chronic migraine (CM), 8 days of migraine eclipses even 20 days of TTH but CTTH is considered to be a serious disease and highly disabling condition. In CM-50% due to Medication overuse (MOH) but many other more common chronicization factors like fever, trauma, obesity, depression and sleep disturbances etc. are not mentioned.

Unilateral aura in typical aura and monocular aura in Retinal Migraine are not easy to digest for any junior/resident who try to learn/master these criteria. It is well known fact that nasal auras are difficult to recognize clinically because of limited nasal field and auras start paracentrally but Homonymous nature of aura has been abandoned by ICHD 3 Beta, the very basic of visual aura science. Menstrual migraine is still in the appendix with more than a page devoted, why not considering it as another trigger and all other documented triggers to be included in ICHD 3? In group 2 (infrequent episodic tension type headaches - 2.1), it is stated that at least 10 episodes of headache occurring on <1 day per month on average (<12 days/year) and fulfilling criteria B-D, and criterion B is LASTING FROM 30 MIN TO 7 DAYS. These statements are really confusing/not very helpful when trying to differentiate mild migraine/
stimulate interest in headache medicine in residents and post graduates.

Episodic syndromes (1.6) are migraine associated/related/ precursor disorders with brief duration attacks lasting minutes to hours. Sine qua none of episodic syndromes is ABSOLUTE NORMALITY IN BETWEEN EPISODES-Why not the same applicable to migraine? Why no PROBABLE Diagnostic criteria in Episodic Syndromes? (Barany society has recognized Probable Vestibular migraine). In this region of the world, many children present with abdominal migraines with less than 2 h duration [8]. Many well documented migraine entities are not even in the appendix- Alice In the wonderland syndrome/Refractory migraine/ Dysphrenic migraine/Migraine with autonomic symptoms, etc. RED FLAGS NOT HIGHLIGHTED - MOST WORRISOME FOR ANY PRACTITIONER in the third world due to the increasing medico legal threats. Again, to familiar with and identify red flags, one has to master all the groups. Patient behavior is not mentioned in PH/SUNCT/SUNA. Agitation/restlessness and pacing the floor is not mandatory to diagnose TAC, then how to differentiate most of the TACs from brief unilateral migraines (migraine is always unilateral in ICHD) with autonomic symptoms suggestive of Trigeminal autonomic reflex activation? [10]. Is Hemicrania continua a mild headache disorder as it is written OCCASIONAL EXACERBATION TO MODERATE OR GREATER INTENSITY. Very important differentials like Sub-acute angle closure glaucomas and recurrent corneal erosions are not mentioned. Some very brilliant juniors/residents with great passion for headache science keep on asking me if restless/hyperactivity/irritability can be migraine premonitory symptoms [11] and migraine related Episodic syndromes can be of minutes of duration , why not TAC a migraine variant? After all, oculonasal autonomic manifestations, many documented triggers and symptomatology are same and the treatment also very much similar to migraine like Ergot, Tryptan, Indomethacin and Anti epileptics. Indomethacin is the drug for excruciating pain like PH (Paroxysmal hemicrania)/HC (Hemicrania continua) and also for mild to moderate headaches like primary stabbing and Hypnic headaches? Why not other powerful NSAIDs like Diclofenac/Naproxen/Piroxicam in this category? Most of the Gr 4 disorders when presenting for the first time, are ominous except Cold stimulus, External pressure and Primary stabbing - Why still they are in the Primary Headache Disorder group? New daily persistent headache (NDPH) is a very ominous red flag presentation which need all possible investigations but still considered as Primary? In Primary Thunderclap headache (Gr 4) - maximum intensity of pain within less than 1 min is fine/ but other presentations also to be mentioned (like in Gr 6 - non traumatic SAHge - persistent/intense/incapacitating/moderate intensity but abrupt onset is the key).

Chronic subdural hematoma, a very dreaded presentation in any busy outpatient clinic, is missing in ICHD 3 beta but very much there in ICHD 2. When I communicated this to Professor Todd, Group 5 chair, he found this recommendation EXCELLENT (personnel communication). It is better that Genetic vasculopathies are in Gr 1, so that basic practitioners are familiar with these rare presentations as migraine with or without auras (with atypical features like prolonged auras, episodic vomiting, sensory neural deafness etc. in parenthesis). Only four symptoms are given under Pituitary/Hypo hypo/hyperfunction - numerous other symptoms like peripheral and other visual disturbances, menstrual irregularities, galactorrhea, sexual symptoms, skin change, etc. to be highlighted. Headache attributed to brain neoplasm has only three symptoms - Nocturnal awakening/not able to sleep due to head pain, side locked pain etc. are equally important symptoms. If cold ingestion like ice creams or similar dietary items can be in other primary headache group/Why DIETARY/ALCOHOL, etc. given in Group 8? In Gr 8, 8.3.4 (Headache attributed to withdrawal from chronic use of other substances) - if there is no sufficient evidence, why this entity still in the official group and not in the appendix? In Group 11, it is stated that migraineous features such as nausea, vomiting, phonophobia and photophobia may be present in Cervicogenic headaches and that makes diagnosing this entity very challenging. Appendix entities in this group like Headache attributed to upper cervical radiculopathy and cervical myofascial pain create more confusion than clarity. In Glaucomas - important symptoms/signs like halos/pupillary changes etc. omitted. Gonioscopy is not routinely done in ophthalmic work up and recent investigations like US Bio microscopy/Anterior segment Optical coherence tomography (AS OCT) are not mentioned. Uncorrected refractive errors can trigger migraine attacks in a person with migraine diathesis and it is well documented that Convergence insufficiency too can cause mild to moderate periorbital headaches but missing in ICHD 3 beta. Idiopathic orbital inflammations are more common presentention than Trochleitis but neglected. Trigeminal neuralgia with autonomic symptoms, Nervous intermedius neuralgia with disorders of lacrimation or salivation, Aeroplane travel with 10% with autonomic symptoms, Epicrania fugax with autonomic sympotms - Why not considering them as TACs? Co morbidities which are therapeutically very significant for any clinician, not given due significance and an extremely rare disorder like Raeders syndrome has suddenly popped up from nowhere bypassing the appendix.
References


