THE ICHD-2 DIAGNOSTIC CRITERIA ARE USEFUL AND NECESSARY FOR CLINICIANS AND RESEARCHERS

Jes Olesen
University of Copenhagen, Danish Headache Centre, Department of Neurology at Glostrup, Glostrup, Denmark

Let us think back for a moment to the time before the advent of the ICHD-1. There were a lot of descriptions of what people understood by migraine but they were very discrepant. So one doctor would diagnose migraine in a patient but another would not and treatment would vary dramatically. Even worse for scientists. If published results were contrary to the belief of one scientist he would always claim that the patient material of the other was different from real migraine. The only guidelines at that time were the so-called criteria of the ad-hoc committee of the NIH published in 1964. They were merely short descriptions and full of relative statements such as "Headache is usually severe, is often unilateral, is sometimes accompanied by visual disturbances." etc. At that time headache disorders were generally regarded as psychosomatic, poorly defined with no objective findings and the whole field had a very low status within the neurological community. Headache did for example not appear as a major topic at any world congress of neurology until the late 1980s. The first edition of the international headache classification, the ICHD-1, was published in 1988 after three years of work by more than a hundred headache experts around the world. There were extensive hearings throughout the headache and neurological communities and a beta version was published a year before the final publication to make input possible from the broadest possible forum. Almost miraculously it proved possible to create a classification with explicit diagnostic criteria for all headache disorders that was universally accepted and stood the test of time. In many cases the first diagnostic criteria were based more on expert opinion than on published evidence but subsequent evidence has almost invariably supported the opinion of the experts. Headache went from being the worst classified and defined subject within neurology to become a leader in the field. The second edition in 2004 with subsequent revisions did not provide a big advance but a number of new entities were included for the first time and most importantly medication overuse headache was recognized as a specific entity. Both ICHD-1 and ICHD-2 have been accepted worldwide, translated into more than twenty different languages and there are no competing classifications.

Success, success, success but what does it mean to the practicing physician? Nobody is supposed to learn all the diagnostic criteria by heart but certainly the criteria for migraine, tension-type headache, cluster headache and medication overuse headache are essential knowledge for every practicing physician who sees headache patients. The rest of the classification is used for looking up criteria when a case of doubt occurs in the practice. The clinician does not any more need to ask a lot of previously used questions to patients but can direct the interview according to the requirements of the classification. Since the great majority of patients in clinical practice have a primary headache and this is clear within a minute or two, it is possible to concentrate on the differential diagnoses between the different primary headaches. Thus, attackvise occurrence, severity of headache, half-sidedness, pulsating quality, aggravation by physical activity and presence of nausea, photophobia and phonophobia are essential questions, but burning, cutting and other qualities are not. Half-sidedness is important but frontal temporal or occipital location is not useful in the differential diagnosis of primary headaches.

For research the classification has been revolutionizing. No more can surprising new findings be put aside with a remark about an erroneous diagnosis. Epidemiology and economic cost of headache disorders could not be studies before the classification. How can you define the prevalence of a disorder if you cannot diagnose it in a consistent and precise way? This was made possible by ICHD-1 and -2. For genetic research the same is true. Familial hemiplegic migraine was separated out already in ICHD-1 and this supported finding the FHM genes. In therapeutic trials the same is true. The whole triptan programme was built around the ICHD-1 diagnostic criteria for migraine and in fact the very high efficacy of injected sumatriptan (80% response) is the best external validator of the diagnostic criteria for migraine. Today new therapies always based on ICHD-2 diagnosed migraine and hence, efficacy is only proven for patients fulfilling ICHD-2 criteria.

In summary, the ICHD-1 and -2 have been of immense importance for the headache field both from a clinical and a scientific perspective. Where would we be if ICHD-1 and -2 did not exist? We would still be a disregarded field of neurology and patients would not receive a precise diagnosis or specific therapy.