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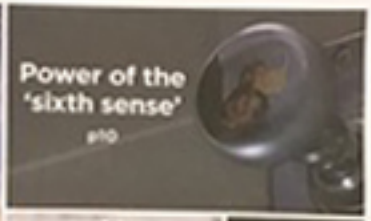

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THE Medical Republic

Better together

Continuity of care could save billions

RUBY PROSSER SCULLY

Patients who see the same GP are less likely to be admitted to hospital unnecessarily, potentially saving the healthcare system billions, new research shows.

While efforts had been made to improve access to primary care, those efforts might have had the unintended side effect of reducing continuity of care, the authors of the British study wrote.

In fact, continuity of care tended to be worse in larger practices, they found.

RACGP president Dr Bastian Seidel said the research reinforced the importance of what GPs had instinctively known – that the best care was delivered in small, quality general practices.

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Gillespie champions new training focus

Good policy is not just about clinical decisions, says the assistant minister for health

JULIE LAMBERT

The first medical professional in decades to have a slice of health policy action, Assistant Health Minister Dr David Gillespie, is steering a medical workforce shift that is pleasingly in step with most doctors' views.

The Nationals politician, elevated to federal parliament in 2013, announced last week that responsibility for GP registrar selection would return in 2018 to the RACGP and ACRRM after 17 years in the hands of the Health Department.

"I think the colleges, which set the curricula and do the standard keeping, have a better feel for what makes a good GP. The department will still make sure candidates are eligible, but the colleges will run the selection process," the Assistant Health Minister, a practising gastroenterologist for more than 30 years, told *The Medical Republic* in an exclusive interview.

"The phenomenon is that some people at a junior stage of their career just pick general practice because they've got no idea of what they want to do. They start general practice training and then they drop out," Dr Gillespie said. "Having the colleges select the candidates will, I think, get a lot of more committed people, rather than people who are at a loss and don't know if they want to be a registrar in a hospital or work in general practice or do whatever."

Dr Gillespie was promoted from assistant minister for rural health to a broader role in Malcolm Turnbull's cabinet reshuffle after former health minister Susan Ley's resignation last month over a travel expenses scandal.

The government had realised that general practice in Australia needed renewal to end a reliance on overseas-trained doctors, an awakening that led it to allocate $200 million a year to support up to 1200 registrar places annually, he said. But the coming appointment of Australia's first Royal Health Commissioner would be the game changer.

Legislation to set up the new statutory position was in the "express lane" for introduction in the autumn sitting of parliament beginning on February 7, Dr Gillespie said he could not imagine any side of politics opposing the appointment.

"It has been a campaign commitment and we are going to deliver it."

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Underdiagnosed and over self-medicated, migraines are one of Australia's biggest health problems.

Headache Australia estimates that there are up to three million migraine sufferers nationally - between 10 and 15 per cent of the population, yet Headache Australia also states that 50 percent of migraine sufferers have not been diagnosed.

Added to the migraine mix is that sufferers are predominantly women in their reproductive years, giving new seriousness to the excuse 'not tonight, I have a headache'.

"Migraines are underdiagnosed," says neurologist Richard Stark, Associate Professor at Monash University. "If you think they [the patient] do, they probably do have a migraine."

Migraines are Missed

The international classification of headache disorders distinguishes a migraine without aura (hemicrania simplex) as a recurrent headache manifesting as at least five attacks lasting between four and 72 hours and exhibiting two of the following characteristics:

- a unilateral location
- a pulsating quality
- is of moderate or severe intensity
- is aggravated by routine physical activity.

Associated nausea and/or photophobia and phonophobia also firms up the diagnosis.

However, some patients have the classic migraine (ophthalmic) that have aura symptoms ranging across sensory, speech and / or language, motor, brainstem and / or retinal. For an aura migraine to be diagnosed, two of the above symptoms must be present as well as at least two of the following four characteristics:

- at least one aura symptom that spreads gradually and two or more symptoms occur in succession;
- that each individual aura symptom lasts between five minutes and one hour;
- at least one aura symptom is unilateral and;
- the aura is accompanied or followed within an hour by a headache.

Particularly for migraine sufferers who don't have classic aural symptoms, the migraine is often confused with a garden variety tension headache.

According to A / Prof. Stark, the formal diagnostic criteria can be fast tracked to a three prong approach: does the patient have a headache severe enough to limit their activities? Is there associated nausea? And thirdly, is there associated light sensitivity?

"If there are two of three, there's a strong likelihood of a migraine. When I speak to GPs about migraine, you see a light going on - that they are seeing patients who seem to have tension headaches when it is really migraine," A / Prof. Stark explains. "It's been found that really detailed headache diaries and associated symptoms that were thought to be tension headaches actually were migraine. If we make a diagnosis of migraine it opens up the treatment."

Treatment and Triggers

As understanding about migraine has deepened, so have the treatment options for GPs with patients suffering migraines. For patients who do not respond to medication, want to avoid medication, or are experiencing withdrawal headaches, advances in TENS technology such as the CEFALY device are an alternative, or can be combined with medication.

"There are three treatment strategies," says A / Prof. Stark. "The first is avoiding triggers, and a lot of patients do that themselves. In general, migraines have nothing to do with diet - it can be the trigger not the cause - but having said that dietary factors can influence the onset of migraines.

"Some are sensitive to eating food stuffs to certain cheeses, red wine, artificial flavouring or MSG. There's no rhyme or reason." Migraine sufferers can also be triggered by hot Summer days and other environmental factors. The second strategy is to deal with an attack as it occurs, and the third is prevention which also relates to avoiding triggers, although that's not often possible.

While migraine medication is now more advanced since the early days of migraine treatment, some common painkillers can worsen the situation.

"You end up with rolling withdrawal headaches from opiate codeines as the body becomes acclimatised and quickly habituates," says A / Prof. Stark. "The first thing a person does with a withdrawal headache is to take more codeine, and that in turn perpetuates the cycle."

Side effects must be also considered and the 'side effect' of not taking the medication at all.

"None of the migraine medications are perfect," says A / Prof. Stark. "Pizotifen's main side effect is it makes you hungry. So if you have a person who is thin, who has never had a problem with weight, it's OK. But if you have someone who's been battling with their weight for years; then Pizotifen may not work for them." Ditto giving beta blockers to a migraine sufferer with asthma due to the risk of the drug impacting their condition.

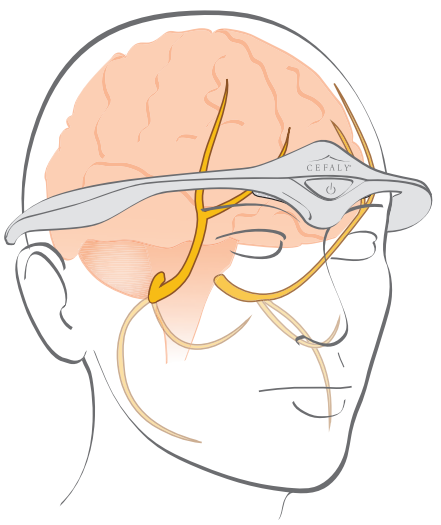
"If you aren't getting anywhere because of side effects, or medication doesn't seem to be effective, or you have a patient who says, 'I don't want to take medication', things like CEFALY become a reasonable option," says A / Prof. Stark.

Beam me up, CEFALY

CEFALY harnesses electric impulses to treat migraine pain with neurostimulation that limits pain signals from the nerve centre, working on the trigeminal nerve. It's also convenient and lightweight - CEFALY has been described as being more akin to a Star Trek headband than a cumbersome TENS machine.

"It is suitable for people who have struggled with the side effects of other medication and certainly for patients who have an aversion to taking medication every day," says Dr. Len Rose, from the Melbourne Pain Clinic, who setup with colleagues one of the first private pain clinics in Melbourne.

Randomised, double blinded controlled clinical trials have demonstrated efficacy and safety of the CEFALY device for the treatment of migraine with or without aura. It was also approved by the FDA in the US in 2014.



"A study published in the *Journal of Headache and Pain* in 2015 showed that 80 percent of patients who used this device continued to use it, and migraine days reduced from 6.5 to 3, and migraine attacks reduced from 4.5 to 2.06. There's substantial reduction in some of the most essential complaints involved with migraine," Dr. Rose comments.

"The way it works is that the patient puts it on and there is a stimulus where it is attached on the bridge of the nose between the eyes," Dr. Rose explains. "It starts off as a soft buzz and builds gradually. Within three or four minutes the buzz becomes uncomfortable so you press a button so it stays at that level for each 20 minute session. But each day you get further along (before pressing the button) - that tells you are reprogramming the pain pathways."

As nerves are polysynaptic, inputs are modified as they receive new stimulus. "It's like rubbing something that is sore actually helps," Dr. Rose says.

CEFALY has no side effects beyond some patients finding the Gel Electrode Pad between the eyes sticky and a minority of patients have a skin reaction to the gel, which Dr. Rose says is consistent with electrostimulation studies.

Another alternative or adjunct to medication and / or CEFALY is mindfulness meditation. At the Stress Reduction Clinic at the University of Massachusetts Medical Centre, Dr. Kabat Zinn uses mindfulness for chronic pain as well as stress.

"It [mindfulness] needs to be tested rigorously but it's not ludicrous that things like that will make a difference," says Dr. Rose. "You need to have a multi-disciplinary approach."

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(1) **Journal of Headache and Pain 2013:** Magis D, et al.
(2) **Neurology 2013:** Schoenen J, et al.

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