Commentary: The Pediatric Migraine Connection

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Should biobehavioral intervention be the first treatment option considered by pediatricians and pediatric neurologists in the management of recurrent headache disorders of childhood? I believe the answer is, yes. Not one but several treatment techniques falling under the biobehavioral rubric have produced clinically significant results for most headache subtypes in children. Furthermore, these techniques are well described, readily implemented by properly trained clinicians (with the possible exception of biofeedback), and complementary to medical therapy. Perhaps, most important in the era of managed health care, treatment is typically short-term. So why, after 18 years of clinical experience and 31 published investigations later, is biobehavioral intervention not highly visible in the treatment armamentarium for pediatric headache syndromes?

One reason for this shortcoming is that we need to effectively disseminate information to parents, pediatricians, and pediatric specialists. For parents and their children, the main selling point is that biobehavioral treatment is the most effective way to control headache without medication for long periods of time. The data suggest with confidence that written material can be generated for health care providers to pass on to patients and parents about the biobehavioral treatment process for pediatric headache, including the expected outcomes. Many professional organizations have begun to develop and disseminate information or “fact” sheets about diseases and syndromes.

The Society of Pediatric Psychology may wish to consider this activity. Local and national media coverage, even though time-consuming and sometimes a frustrating experience, is something that clinicians and researchers should try to accommodate, particularly as the pharmaceutical industry pursues an increasingly aggressive public marketing strategy.

Another reason has to do with access to treatment services (A. Leviton, personal communication, April 2, 1998). Children with chronic and recurrent pain problems cannot wait several months for an initial evaluation. One to two weeks’ delay between referral and initial appointment should be the standard for clinicians offering biobehavioral treatment services for pediatric pain problems. Of course there are barriers to efficient delivery of clinical services, such as when treatment is not covered by a patient’s health insurance. However, in denied coverage, it has been my experience that appeals can be successful by referring to the aforementioned 31 investigations, including sending along a reprint or two. Clinicians should aim for speedy evaluation of the patient even if the start of treatment will not occur for several more weeks. This would allow the clinician to screen for the appropriateness of the referral and offer the patient and parents initial pain management information and suggestions.

Received October 8, 1998; accepted October 17, 1998