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Editorial

Incorporation of health technologies: The importance of drug treatment of primary headaches in the Brazilian unified health system

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Primary headaches have disabling characteristics that allow them to be classified as Chronic Noncommunicable Diseases (NCDs). Currently, cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases are considered CNCD, leaving headaches excluded from this list and, consequently, keeping them out of political attention.[1,2] The non-incorporation of headaches as a CNCD in the Brazilian Unified Health System prevents the user from receiving adequate care when diagnosed with a headache. The care for patients with headache, when included in lines of care, can make it more equitable, effective, safe, and humanized, ensuring a more appropriate diagnosis and cost-effective treatment for the health system.[3]

Migraine is currently recognized by the World Health Organization (WHO) as the second leading cause of disability worldwide, first in those under 50 years of age and first in Western European countries and Australia.[4] In Brazil, evidence shows that about 30 million people suffer from migraines, 5% to 25% are women and 2% to 10% are men. That is, migraines are 2.2 times more prevalent in females.[2,4] The total number of records of specific hospitalizations in Brazil from 2014 to 2018 due to migraine and other headache syndromes was 42.9 thousand, representing 0.09%, about 7.8 thousand hospitalizations for this condition. The annual average of general hospitalizations in Brazil is approximately 10 million, with a proportion of 0.08%, due to migraine and other headache syndromes.[5-10]

Patients who receive a definitive diagnosis and treatment in managing headaches and, above all, prophylactic treatment, in primary care have a better quality of life, in addition to causing a considerable decrease in the number of visits to secondary care and hospitalizations.[11-14] That is why it is essential to train professionals working in primary care through matrix support in health with the help of specialist physicians working in specialized centers to manage headaches.

There is no record of Clinical Protocols and Therapeutic Guidelines (CPTG) by the Ministry of Health (MH) for the drug treatment of headaches in Brazil. Physicians working in the unified health system or Supplementary Health use protocols and consensuses published by headache and neurology societies, care protocols, or international guidelines.[15]

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The absence of clinical guidelines or protocols makes correct drug treatment difficult because there is no specific ICD related to adequate technology for the treatment of headaches and migraines by the unified health system.

In Brazil, the prescription of drugs within the scope of the unified health system is based on decree 7,508/2011 that regulates law 8,080/1990, in which universal and equal access to pharmaceutical care presupposes simultaneously being prescribing drugs following the National List of Essential Medicines (NLEM) and the CPTG or with the specific supplementary state, district or municipal list of medicines. Making it mandatory for physicians working in the unified health system to reliably prescribe or exhaust all medications available in NLEM.[16] The National Commission for the Incorporation of Technologies in the unified health system is responsible for proposing updating the NLEM every two years and evaluating the incorporation, alteration, or exclusion of technologies, based on the receipt of spontaneous requests, as per Decree No. 7,646 of 2011.

Specific drugs for migraine attacks, such as triptans and ergotamine derivatives, or non-specific drugs, such as simple analgesics and non-steroidal anti-inflammatory drugs, NSAIDs are the most indicated.[15] The concomitant use of antiemetic drugs, neuroleptics, and corticosteroids can be used, if necessary, to alleviate other symptoms of the crisis. Dopaminergic antagonists with antiemetic action, such as metoclopramide, domperidone and bromopride, can be useful even when there is no nausea since migraine attacks also cause gastroparesis. Regarding preventive treatment options (prophylaxis), beta-blockers, calcium channel blockers, antidepressants, antiepileptics, neurotoxins, and vitamins/phytotherapeutics are observed. For patients with chronic migraine, there are only two options whose effectiveness in prophylaxis is based on robust clinical evidence: topiramate and onabotulinum toxin.[15] Notably, no currently existing prophylactic treatments were explicitly developed for migraine. Recently, more selective targeted therapies directed at CGRP, monoclonal antibodies indicated for the preventive treatment of migraine, have been developed and approved.[17-27]

The NLEM update in 2022 did not incorporate any technology to treat the main primary headaches, nor did it expand access to medications already incorporated for headaches, such as the use of topiramate medications.[28-33] and botulinum toxin A[34-35], already incorporated into the unified health system to treat other conditions.

Migraine needs to be treated as a public health problem, with the same political relevance contained in the CNCD, paying attention to the damage it causes to people's lives, such as absenteeism at work, drop in productivity, association with psychological, social, emotional and affective nature due to the way it alters the sufferer's cognitive functions. Unfortunately, the consequences of headaches are still a subject of little discussed with the population for planning policies to deal with it. The evaluation of health technologies is essential for the sustainability of the unified health system since it depends on the balance between access, rational use, prices and risks involved in the incorporation of these technologies.

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