Headaches & The EdACHe Project - Ref198

with Liz Huzzey

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TRANSCRIPT

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Steven Bruce
Good afternoon. Great to have you with us as always, and we've got a particularly personal, it's a particularly relevant topic to discuss today. I'm joined by osteopath Liz Huzzey. Now if you've been paying attention over the last two years, you will know that she joined us at the start of what is known as the EdACHe project. I don't know how people come up with these acronyms, but it stands for Education and Assessment in the Competence with Headaches. She'll tell us about that in a minute. But EdACHe says it all doesn't it. So she is the project leader in that, she's also a founder member of Osteopaths in Practice for Headache Management. She has been an osteopath for quite some time now. She's recently earned her master's in Headache Management. I probably got that wrong at university, I think in Copenhagen. But anyway, it's Liz Huzzey. Liz, it's great to have you with us once again.

Liz Huzzey
Hello, thank you for having me.

Steven Bruce
And look at you, you're a jobbing osteopath. You're here straight from clinic.

Liz Huzzey
Straight from clinic.

Steven Bruce
And you are probably, certainly in manual medicine terms, one of this country's experts, leaders in knowledge about headaches I'd thought by now.

Liz Huzzey
Yes, I think I could probably hold my hand up to that. But yes.

Steven Bruce
You don't need to be falsely modest, do you? You started this EdACHe project two years ago.

Liz Huzzey
Yes.

Steven Bruce
And I like to think that we helped to stimulate you to a fair final number of participants. How did you get there in the end?

Liz Huzzey
Obviously for phase one and just for reminding phase one was a study to see the existing headache knowledge amongst UK osteopaths. And that was what we came on two years to ask your help, to get people to participate. And with your help we managed to get 398 participants, which was an amazing number it was almost 10% of the UK population, osteopathic population.

Steven Bruce
It was five times as many as you expected.

Liz Huzzey
Yeah. Yeah. So it gave us a really robust piece of research, and gave us really robust data. It was a very representative number, representative for people in all the regions, Scotland, Northern Ireland, Wales, across all years qualified, all ages, all genders. So it was a cohort that really represented the UK osteopathic population.

Steven Bruce
So that was phase one, two years ago, yeah, has that phase taken the whole of the two years?

Liz Huzzey
No, phase one finished, that took the first six months, we collected the data. So we know where the gaps are, where the knowledge is good, where it's reasonable, and where there uncertainty. So and then for the last 18 months, we have taken that information and we have put together an e-learning course to fill in the gaps that's clinically relevant and academically robust, that was the idea. And that's just been finished now. And we're ready to roll that out.

Steven Bruce
So actually, we now have a fairly robust platform on which to build this, probably as robust as anything in headache management in the UK, certainly, but this is worldwide, isn't it? You've got participants in Australia, I think as well.

Liz Huzzey
We have. I presented it on the globally through an Australian physiotherapist, to Watson, people may know of who's very high up in the headache management department. And so I presented the project through his online symposium, a couple of *audio problems*. At this point in time, we are still in the research basis, because, so phase three, which we're in now is all about doing a before and after to see how effective the e-learning course is at increasing people's knowledge. So it's all aimed at that. But for the purpose of research, we had to define a cohort. And so the one that we obviously identify most with and is the easiest for us to access is the UK practicing osteopath. So for this before and after study that we're writing now and the deadline is in the next 24 hours. If people wish to participate, they'll get the whole eight hour e-learning course free of charge. All we ask is they do a 20 minute clinically relevant questionnaire before and after. So that we can really determine how effective the course is.

Steven Bruce
Right. So they're going to do eight hours of training, all of which is of course valid CPD.

Liz Huzzey
Yes.

Steven Bruce
Could you, I'm thinking off the wall here. Could you conceivably sign up as an acupuncturist or a chiropractor just to do that learning, even if you can't take part in the research?

Liz Huzzey
At the moment, no, but as soon as this is done, which will be the new year, then it's going to be available. In the new year, the data analysis and the writing up will take a little while, but we definitely expect the e-learning course to be available in 2022. And that will be to everybody, obviously.

Steven Bruce
And that e-learning course, I would imagine, based on what I know what you've been doing, and what you talked about, that's going to be completely new, isn't it? It's not the stuff that we learned in college just rehashed, because basically, they didn't know this stuff when we were in college. They didn't know where the evidence led us.

Liz Huzzey
No, it's all about knowledge that you need in clinic. So the premise is a patient walks in with a headache. Do you know the worrisome signs? Are you sure they're safe? Are you confident in your diagnosis? And you know when you can treat and when you should refer? And if you should refer, who should you refer to and why? So it's taking you through that journey to make sure that you have all the knowledge you need to take all of those steps.

Steven Bruce
Can I just go back a step? I said you did a master's, you've just finished a master's, it was headache disorders. You also presented that not just to a manual therapist audience, didn't you?

Liz Huzzey
No, I mean, I was very lucky in that they accepted me on to the master's program, it's really meant for headache neurologists. And so I was the first practitioner within a non-medical framework to be accepted. And they were very open minded and very welcoming. The advantage of it is that we just got the best science in the world to come and present and lecture me so it's the most up to date information on what treatment, on the science and the up-to-date evidence and what we know about headaches, what we know about migraines.

Steven Bruce
How many on the course?

Liz Huzzey
20.

Steven Bruce
Right. But presumably it runs every year and...

Liz Huzzey
Every two years. Yes.

Steven Bruce
Can we assume now... Well, let me start with what I imagine would have been the basis of that course that it would have been largely about conventional management of headaches, which is quite probably drug related.

Liz Huzzey
It is.

Steven Bruce
So now, will it be different? Will it be better?

Liz Huzzey
No, it isn't. But you know, if we're going to start, I definitely believe progress is all about collaboration, and professional respect. And the one thing that they do have is access to the best science. Beyond that the treatment obviously, the treatment modalities that they look at are all medical. But it's still really important because the patients that come in and see you will have been through those journeys. So if you have a knowledge of what medications, acute medications, prophylactic medications, if you have knowledge on Botox, at least you can then give an informed suggestion to your headache patients. So an example would be cluster headache. The best treatment for cluster headaches is fast flow oxygen, or Sumatriptan. And it's probably not, it doesn't mean to say that you can't treat them whether you're an osteopath, or a chiropractor or an acupuncturist. But you can have that conversation from an informed point of view. This headache is known that you've come to see me, I can tell you it's known as a cluster headache, because I recognise the diagnostic criteria. And these are your treatment options. These are the medical options. And then I'm happy to treat as well. But you can make a decision on where you want to go with it. So it's having the knowledge to be safe, and give the patients all the information they need and to treat with confidence, really.

Steven Bruce
Interesting. Just taking cluster headaches because you've mentioned it. Instinctively, one would say, well, a patient wouldn't be in the least bit averse to having fast flow oxygen because oxygen is not a drug. Of course, it is a drug like any other chemical, especially if delivered in abnormal quantities. Does manual medicine fit in to that, do we have a significant role to play or is it just palliative?

Liz Huzzey
Well, you know, I'm passionate about what osteopaths and chiropractors and physios have got to contribute to the headache world.

Steven Bruce
We're going to have to come up with a word, aren't we? Because we always say osteopath and chiropractors. Osteopractors.

Liz Huzzey
I think we've got a massive role to play but at the moment we're on very weak footings because we don't have a strong evidence base. We don't have strong science behind us, so we may have patients that know what we can do, we may have lots of anecdotal stories, but it doesn't really change anything on the bigger picture of the headache world.

Steven Bruce
Yeah, we've got nothing we can go to the GP with and say look, the evidence says that I am a good bet for this particular disorder.

Liz Huzzey
No, I mean, a good example is the NICE guidelines in 2012 that came out for headache recommendations. Chiropractors and osteopaths and physiotherapists weren't, they were there a little bit but not the stakeholders. They weren't really. But acupuncture got in there because the acupuncturists, the BMA and Mike Cummings got some really good data, really good RCT trials, and NICE looked at it and they're now NICE recommendations for migraine prevention is nine to 12 acupuncture sessions. So if we aspire to do that, that's where I'm at at the moment, I'm sure we can do that now. But in order to do that, we have to have people within our professions that know the difference between the diagnostic criteria of a tension type headache, migraine, or a cluster headache, hypnic headache, post traumatic headache, medication overuse headache.

Steven Bruce
And let's not forget aura without pain.

Liz Huzzey
And of course, the psychogenic headache.

Steven Bruce
I only say that, because I admit that I get that from time to time, I want treatment. So that's why you're here, really. I guess everybody's going to ask, you know, what does the evidence, as far as you're aware, currently, say about which manual therapies are available or are effective for which treatments?

Liz Huzzey
They're very low down, you know, the evidence is there, but it's still relatively small compared to the big hitters. And so it always comes as an afterthought, it's always, and physical therapies could help with this.

Steven Bruce
How much did BMA have? The British Medical Acupuncture Society BMAS, how much did they have? Because, you know, I couldn't imagine they're any wealthier than osteopathic organisations in terms of research, but they had enough evidence to sneak into the NICE guidelines.

Liz Huzzey
There would be the advantages that Mike Cummings was a medical doctor, and he understands the language that you need and the science. And he does acupuncture at I think it's the homeopathic hospital in London, so big cohort of people coming through that can get this on National Health Service. So he's got the participants. And he's presented acupuncture in a way that NICE guidelines can understand, I think. That's my take on it, my personal take on it. I mean, there is a big argument about whether the medical framework has got it completely right, and they don't understand. They're only looking at it from one angle. But the fact is that that's majority rules at the moment. So I think collaborating is definitely the way forward.

Steven Bruce
Yeah definitely. I never really thought about how unlevel the playing field is until you mentioned what you just said. If you are a doctor, you've done a lot of medical training. But when you become skilled in anything else, you are entitled to use that as therapy, which means you've got an unlimited number of patients at your disposal because of the NHS system. Of course, unless you're a doctor who is trained in osteopathy, and there are very few who would want to spend another three or four years qualifying in a different medical discipline, that's never going to be one of those options that they use, which cuts on the number of people that you can put into the research pot.

Liz Huzzey
Yes, yeah, I mean, good research is a whole other conversation to be had. But definitely, the more knowledge we have, the better place we are to collaborate with patients, with the medics or with research. So the more solid knowledge you have, the safer and the more effective you're going to be for your patients. And that's after all, what we all do it for, but also, you're going to be able to collaborate and you're going to be able to speak with the GP in a language they understand and they're going to know that you're safe and you understand the limits of your scope of practice. You're not going to try and ignore, going back to the cluster headache, you're aware that fast flow oxygen is a good option and you're not stopping patients to find that.

Steven Bruce
How easy is that to administer? I mean I'd administer high volume oxygen to people in first aid situations before, is it no different to that?

Liz Huzzey
I've never administered it. It's not something I offer. It's fast flow, but I know about it.

Steven Bruce
Is it readily available?

Liz Huzzey
It is, there's a bit of complication because oxygen, it's explosive, flammable and all of that sort of thing. But there is a, you know, OUCH, which is the patient for cluster headache, the patient advocates for cluster headaches. It's called OUCH and *audio problems* patients and get them to contact them or contact their GP, but just giving the patient the right information based on accurate knowledge is so

important. We're in such a perfect position. We have time to ask these questions, we can manage them, even your patients don't come to you with headaches, we know that patients with migraines are more likely to experience pain, by far. They may come in to see you for their low back pain, when you're taking their case history, they may not come to you for their headaches but you're in a great position with good knowledge to really help them manage their and find the right treatments, whether that's treatment or lifestyle advice, whatever makes a difference. It's a really important part of that headache patient's journey.

Steven Bruce
You kind of answered this. Pip sent in a question a little while ago asking whether the program included migraines as well as general headaches, which clearly it does, because you've talked about those already. I often wonder whether migraines ought to be a completely separate subject from headaches because the mechanisms seem to be totally different. Am I right?

Liz Huzzey
Well it is it and they divide the way the framework for the knowledge that's included in the course is based on internationally accepted framework for the headaches you should be able to recognise within the primary care setting. So obviously, those are the worrisome headaches. So won't get to see a huge amount of those but because people will tend to go to A&E or their GP, but if they're not feeling well or if it comes on too quickly, a thunderclap headache. But there are other ones that do slip through the net. And so obviously you need to be able to recognise potential red flags, and what to do with them. How quickly should you refer them to the GP? Or what investigations should they have? That's all in the course.

Steven Bruce
Am I going to be surprised by those red flags? What are they?

Liz Huzzey
Well, these are what we call potential red flags. So this means not every single person with them is a worrisome headache, but it's something that you should just think about. So it would be new onset over the age of 50. It would be any changing headache, obviously sudden headache, the thunderclap headache, anything where there's general unwellness, if there's a history of HIV or cancer, so there's a few that you can just tick off and you need to know those, right, as potential.

Steven Bruce
It's quite strange. I say again, going back to first aid, when we teach first aid, we talk about stroke, and everybody thinks about the FAST test but one of the major potential warning signs of a stroke is a sudden onset of headaches, sudden severe headache. It's not mentioned in any of the campaigns that are going out on the various media from the NHS.

Liz Huzzey
Yes. Well, I mean, fortunately, I think, and that's one thing they press upon, actually most cases head pain is, the pain is the least reliable of the red flags. So that's not one of them. But anyways, so the framework goes through this course. So we start off the course with safety. So then you get to a point of

okay, I know that I'm safe to treat the green flags. I know that this is, I'm okay. And then the next bit is recognising the kind of headaches, and headaches are divided into two primary headache disorders, when the headache itself is seen as the condition itself and that is tension type headaches, migraines, migraines with aura, and tax. These are the cephalgias, cluster headache is the best known one, there's a few others SUNA and SUNCT. And then there are other secondary headaches. So that's when the headache is secondary to another condition. And one already always thinks those have tumors and you know, worrisome ones, but there's a lot in there that aren't worrisome. Cervicogenic headaches would be considered a secondary headache because it's secondary to spondylosis or disc issues or something like that. A post traumatic headache, which we'll see in headache, because it's come after a trauma. Medication overuse headache, that's a secondary headache that we would see an enormous amount of, I see a lot in practice. And if you know how to recognise medication overuse headache and how to deal with it and how to, when it's complex or when it's simple and what to do with it, what the benchmarks are to make it medication overuse headaches, then you can be really helpful to your patients. Because when you come off, that's 50% immediate reduction in frequency and intensity of headaches, if it's medication overuse, just by knowing what to do about it. So that's these. And that's what's in the course, those basics.

Steven Bruce
You make it sound as though it's a nice clear cut of things, someone comes in, you'll immediately be able to compartmentalise them into migraine, medication induced headaches, cervicogenic. But it's not that simple.

Liz Huzzey
It's not that simple. I mean, and there's lots of blurry, there's lots of grey areas, most headache patients will come in, and they'll have two types of headaches, they'll have an ordinary background headache that they can kind of work through. And then they'll have the headaches that make them, floor them and make them go to bed. So clinically it's not black and white. But I think what really helps is having this black and white structure to your case history, knowing what questions to ask and knowing what's important. And I know as osteopaths, we generally end short, same chiropractors and physios. We don't like to put a medical label on it. But what that does do is give us a really strong structure to then know what to do about it. And I think that helps. I know it definitely in my practice, it helps me manage my headaches with some clear boundaries. Obviously, in clinic we know things merge, clinically, things merge, but it does help.

Steven Bruce
One of the key things of course, in good outcomes for patients, as well as safety is making your decision on what it is you're treating based on good evidence, isn't it? That knowledge of what the signs and symptoms everything else could be, and I suspect my tutors will say it's because I didn't pay attention. But, you know, when I came out of college, I don't think I really considered the different causes of headache. It was very often a case of well, manipulating the upper cervicals often helps with the headache. Let's try that, which isn't a good basis to justify yourself in the subsequent court of inquiry.

Liz Huzzey
No. And the fact is C2, 3, upper cervical efference are hugely important in headache pathways, whether it's via the trigeminal cervical complex, and the part that plays in migraines, whether it's a cervicogenic

issue is hugely important. So what this does is not change your treatment, I haven't found it's changed my treatments, I'm still fundamentally an osteopath, but what it's done it's given me the knowledge to use my treatment with confidence, knowing that I'm safe, and I'm clinically relevant. And I have given the patient in front of me all they need to make an informed decision.

Steven Bruce
Actually, we were talking about this in a case-based discussion on something similar a few days ago. And very often you cannot come to a firm diagnosis. And so you think well, I'll do what I've done in the past, because quite often that's helped. And then we monitor and see what happens, obviously working within the bounds of safety. And as you say far better, particularly with something where there are potentially some big red flags, far better to work on the basis of good education and even if you get it wrong, the fact that you followed the right process and you've made your diagnosis on the basis of those key points are really, really important

Liz Huzzey
Yeah, very reassuring to you, as a clinician very reassuring to the patient. And, again, you can use this clinical reasoning.

Steven Bruce
You might know the figures behind this. I'm springing this on you because it's just occurred to me, but I would venture to suggest that an awful lot of patients who have headaches don't go for any form of medical attention. They'll go to the shop and buy some paracetamol or some aspirin, they'll just take their drug and hope it goes away. Have you any idea how many of those might be helped by some sort of intervention? Not necessarily osteopathy, chiropractic?

Liz Huzzey
Well, I think the few statistics, I think 95% of people will have a headache at some time in their life. Around 14%, and that's pretty globally, whether it's developed or undeveloped, 14% of women will have migraines, 11% of men will be migraine sufferers.

Steven Bruce
Do we know that those are actual things or are they just reported migraines? I'm guessing it must be the latter?

Liz Huzzey
They have but there's been a huge study. Steiner's done some huge epidemiological studies over the last 10 years across the world, global burden of disease, of headaches, so they've got real data from, say from Nepal to Argentina to Africa to Europe, they've got a really good map and it's pretty, I think South America is quite high and Japan is a little bit lower. But generally, it's pretty much the same across the board. So that's Steiner's work, epidemiological study that's really put headaches up on the political and health agenda, public health agenda. It's now number three on the World Health Organization list. So we've got low back pain, anxiety and depression and number three headaches, and what are the three things that probably come through our front door? So we need to know about it.

Steven Bruce
Turning back to migraines. Christina has said that she can see off inverted commas a migraine as it first shows itself by giving C2,3 a flick, her terminology, it's also associated with the stomach meridian. Now, I don't know which professional Christina is, but clearly, she's to poke some needles into something I would have thought from that. Is that what you'd have thought? You could see off a migraine from C2,3 adjustment?

Liz Huzzey
I don't know, I've never known any robust data to support that. But I understand, as I said before, we know that the cervical afferents C1-3 feed into the trigeminal cervical nucleus. And we know that it's complex. And we know that's the engine room of migraines. But alternatively, I think probably you'd get as many people saying, particularly patients, if you have vigorous treatment to C2,3, it will trigger a migraine.

Steven Bruce
What is it that defines a migraine as opposed to any other sort of headache?

Liz Huzzey
A migraine, is a genetically predisposed neurological, completely reversible neurological event. So it means you got to have the genetics. Normally, you'll have either a parent or a grandparent who will have and that's one of the questions you need to ask, because that will help you with your diagnosis.

Steven Bruce
But they haven't identified a specific genetic marker itself?

Liz Huzzey
No, I think there is some in genetics, but there's a lot of work going on to that. But it's not something that I know anything about. But it's a completely reversible neurological event. So when you're talking about your aura without the head pain, your migraine, that aura is a neurological event. It's a cortical spreading, wave of negative and positive ions sweeping through your visual cortex. And that will give you those scotomas and it'll come, and it will go to be reversible within 20 minutes, generally around that sort of time. Will leave you washed out; we now know with functional MRIs. And that's where the science from the University of Copenhagen, it was so great because it came from Harvard and came from Kings and you got a functional MRIs now watching this so that what we know about migraines, it's so much more. It is a neuro vascular event. It's not a musculoskeletal event. Yeah. And I think if you know that, I do believe that the neurology and modulating neurology with techniques can feed into that. I think we we still harbor back to the old musculoskeletal causes for migraine, we're never going to be listened to because the science is just not backing that up.

Steven Bruce
That's so often true about everything we do in our profession, isn't it. Because long ago, we had these theories about what it was we were treating, what we were doing. I don't want to get into any specific areas. And actually, we don't really have any proof that our theories were true, we just know that the

treatment was effective. And if the treatment isn't addressing those neurological components, but something else which is feeding into them, that's good, but we still got to prove that.

Liz Huzzey
I think we've just got to, I think we've got to, you know, evolve and learn and try and be curious and say, okay, I mean, that's one of the whole reason I started this project was because I'd had 25 years in practice. And I knew that some patients responded very well to my treatment of headache patients, really well. And I knew some didn't, and I didn't know why. I couldn't tell the difference.

Steven Bruce
Can you know?

Liz Huzzey
I think I probably can, well, better than I could for sure.

Steven Bruce
It'll never be 100% I imagine.

Liz Huzzey
But I think I've got the knowledge to definitely fill the gaps. And through that I'm more confident, definitely clinically more confident to treat and do what we all do really well, which is treat effectively.

Steven Bruce
Christina has admitted to being a chiropractor and doesn't do her own acupuncture. But that was the origin of her intervention a moment ago. You've produced a video, haven't you, about the next stage of the EdACHe project?

Liz Huzzey
Yes. So this video, hopefully, you're going to see it now. And it starts off, you'll see this at the beginning of the course as well. So what it is, is an everyday patient that you would see in your clinic with the questions. And I'd like you just to watch it and then work out what it is. Is there any signs in there that you would be worried about? Would you refer this patient? If you would refer them, why would you refer them? What would you want from the referral? Or would you be confident to go ahead and treat them, or do you think you should send them somewhere else?

Steven Bruce
Brilliant. Let's have a look at the video.

Video
Mrs. S is 57 years old. She asks if you can help her with her headaches. The very strong throbbing pain is always around either eye. She has had eight attacks lasting three days over the last 30 days. She visited A&E and her GP, but nothing has helped her headaches. So now is looking for answers on her own. She has had migraines since she was 12. But they always went away with tablets she got from her chemist, once in her 20s, they were so bad, her face and arm went numb down one side. The brain scan

was normal. They said it was stress. For years she has taken painkillers for the neck, lower back and knee pain. Nothing works now. Could it be something in her neck causing the pain, she asks. This course will give you the confidence to know what questions to ask, to recognise what kind of headache it is, to refer appropriately or help her find the right treatment.

Steven Bruce
I like that video. Because it's the second time I've seen it, but it throws up all sorts of questions in your mind, doesn't it? 57-year-old woman. Oh gosh, because there's bound to be some menopause or components in that. And then there's some drugs thrown in a bit later on and visual components and what would you do with that lady?

Liz Huzzey
Well, I can't say because other ways our before and after study will be completely put...

Steven Bruce
Okay, so what do you want to get from that video? So you need more participants in the next phase of this project?

Liz Huzzey
Yes, well, it's really helpful for us at this stage. So the whole project, we tried to be as robust as possible, which is why we bothered to do phase one. So we found the existing knowledge and where it was good. And it was good in many places, where it was reasonable, where there were gaps and where there was a lot of uncertainty, then now we put this e-learning course together based on this framework of knowledge that we know people should have in a primary care setting. And now we're at the point rather, we could just roll it out. But because we want to make sure that it's really robust. We've done this in collaboration with the University College of Osteopathy and with NCOR. So we want to make sure that, I mean, just giving people knowledge doesn't mean to say they're going to take it on board to make it clinically relevant. So we want people to take a 20 minute questionnaire at the beginning, and they're all clinically relevant cases. And there'll be a few questions on what you think's going on. And then do the eight-hour course and then answer some similar questions at the end, to see if that journey, the course is taking you on a journey and has actually given you the knowledge and the tools to be effective in the clinic room. And once we can put that data together, then we're really confident to roll this out. Now when we roll it out, we'll probably break it up into modules of two hours e-learning and face to face courses, but that's another conversation we can have. But for now, we need people. The deadline is actually tonight, midnight tonight for people. It's free to unfortunately and I'm really sorry all the chiropractors and physios. But at the moment we had to choose a cohort because it is research. So we have UK practicing registered osteopaths. You can get the eight hours free. If you just send an email to, I think you've got it coming up is EdACHesthree.ophm.org. And we will do the rest. We'll send you all the stuff that you need to do. I've managed to extend the deadline because I knew I was coming on here today. So for you guys, and for your viewers, I've extended it till midday tomorrow. So yes, it's eight hours a week. They're 20 modules. Each module is designed to be around 30 minutes, so fits perfectly into an appointment, you know, an empty appointment slot in your day. So that's an hour a week really for eight weeks, this side of Christmas and it will, once we get this, again it's all being presented to the medical profession to my people back to the neurologist back in Copenhagen. So it's a really good opportunity to get the knowledge and really

show the world that we're taking it seriously. We're taking our role seriously, we're being accountable, and we're gaining the knowledge we need.

Steven Bruce
On the plus side for the chiropractor's, it means they don't have to do this, but they can still come on the course the face-to-face course, once this three or four month segment has been completed.

Liz Huzzey
Yes, once we've got this, and we've got the data, and depending on the data, this can be feedback to, I think there's free text feedback. And we might have to make a few tweaks to just you know, if its response to make so we can make it better. But the finished product, we're trying to make as high-quality as possible. There's nothing in the course that cannot be backed by academically robust papers. So it's up to date and it's robust. We will keep it up to date on an annual basis, the team, five of us at OPHM. So we're constantly reading the research that's coming out, and we will update it all the time. But going forward, to make it user, because I think we're all a bit screened out at the moment. Well, I think, you know, going forwards, we're thinking, okay to make, we'll probably put it into module, say one module on safety and case issue taking, we'll send you the e-learning modules, and then we'll do face to face where we can have interactive role playing, make it far more, so you can get the knowledge and put it into a real-life situation. And we can tell you our experiences, and how best we do it in our own clinics.

Steven Bruce
And on that note, you are probably, if not the final, one of the very last guests who will ever appear in this studio, because we're moving our studio. And we're having a much bigger studio. But I'm going to lock you in this one until you agree to have run one of your face-to-face courses in the new studio, which will be much better.

Liz Huzzey
Well, I will have to check with the rest of the team. But I'm sure it will be...

Steven Bruce
You're not getting out of here until you agree.

Liz Huzzey
I'm sure Yeah, I mean, we're making plans already going forwards. But the course itself would definitely be rolling out.

Steven Bruce
You're going to run it around the country, aren't you?

Liz Huzzey
Yeah, I mean, that's the idea. The idea is that we'll have teams of two, and we will take it the face-to-face days to you. So we can do some up in Scotland or Wales or, but obviously the e-learning modules you can do beforehand. So it makes it effective.

Steven Bruce
I got a technical question for you.

Liz Huzzey
Okay.

Steven Bruce
Sharon says, could you explain the hormonal causes or reasons for headaches, particularly in menopause and how to manage it, in the space of two minutes.

Liz Huzzey
Oh, massive question. Massive question. Well, there's two types. There's pure migraine, pure hormonal, menstrual migraines. And they are the category where there's no other factor. It is pure hormonal migraines. And so they're the ones always happens, you know, in your cycle, usually starts as soon as you're 11 and it goes when you're pregnant and changes again when your hormone levels are changing, and there's pure menstrual migraine, but they are such a small part, the most are what they call menstrually related migraines, where it is a factor, but it's not the only factor. So when it comes to menopause, the same can be applied. Now, there's so much now about menopause at the moment, and the same things apply to the migraines, lifestyle stuff that you know, try not to have, you know, a low GI diet so that you don't have sugar peaks and troughs and try and get some exercise, we know aerobic exercise, 70% max heart rate not 100%. So if you go hard workouts will probably make your migraines worse but around 70%, that's a brisk walk, they definitely make it better. There are some supplements that are really good for migraines, and coenzyme 10 is riboflavin magnesium. And that's regardless of menopause. But there's the coenzyme 10 magnesium can be helpful. You know, they can be helpful around there.

Steven Bruce
Is this sort of information available on the OPHM website?

Liz Huzzey
It is available in the course.

Steven Bruce
In the course.

Liz Huzzey
Not all of it, some of it.

Steven Bruce
We do need to encourage osteopaths to sign up for this course and reassure the chiropractors that it will be available.

Liz Huzzey
It definitely will be. We're not keeping anybody out. It's just as I say, we had to choose a cohort and that's one we could access.

Steven Bruce
The part of that question was, you said that it's hormonally related, what actually are the hormones doing to provoke that pain? Do we know?

Liz Huzzey
I won't profess to be an expert on menopause at this point. So there's various papers now looking at migraines and some metabolic changes. There's all the neurophysiology that creates sleeplessness, we know sleep and headaches go hand in hand. So the sleeplessness that you get with menopause can also feed into the migraine pattern. So I it's a big question. And when your patients come in and they are menopausal, their options for the menopause, you kind of got to separate into two things. Okay, shall we just become, deal this is a menopause, and your migraines are an expression of the menopause that's going on. So let's stick with the menopause and those options all down to patient preferences, some patients just, are very happy. And it's really important to remind ourselves, it's not our preferences, it's the patient's preference. And some patients are very fine taking medication and HRT or amitriptyline for tension type headaches or propranolol for migraine, they're fine with it, it doesn't bother them.That's their choice. They are effective, but there are equally patients that really don't want to take medication so to be able to offer them accurate information, so they can make an informed choice about how they want to deal with it, is really our job, I think.

Steven Bruce
We've probably got time for one more question on this. Actually, I'll feed something into you now. Helena Bridge? I don't usually read out people's surnames. But we all know Helena. She says you're a superb ambassador for this project and says thank you, which I'm sure everybody else would agree on.

Liz Huzzey
Thank you.

Steven Bruce
Helena has been part of the project as well, I think?

Liz Huzzey
Yes. It's a team of four of us, five of us. We Vinod, Helena, myself, Mark McWilliams and Corina Breukel. Helena and Vinod did their headache campaign masters up at the University of Edinburgh, I did mine in Copenhagen. Mark did his in Cardiff. Karina is studying at the moment, but she's got a daughter but was an osteopath trained to be and had cluster headaches. So she comes from a very, from that point of view, very knowledgeable. And we so the four of us together, or five of us together have brought lots of things to the table. But we have one, all for one reason is that we were all experienced osteopaths, all with the same questions. Why did these patients respond well? Well, why did these patients, why don't they respond as well? Or at all? Should I be sending them somewhere else? Or am I missing something that I should be worried about? They're all the same questions. And this project could not have happened

without the collaboration of NCOR and UCO. No, because they've been a huge support for us. And the OF have funded it. So Osteopathic Foundation.

Steven Bruce
Which is wonderful.

Liz Huzzey
It's quite a massive collaboration there.

Steven Bruce
I have one question still in hand. There's one quick one from you Catarina, who asks which magnesium is good. Is it magnesium citrate?

Liz Huzzey
That's the one that seems to be come up tops.

Steven Bruce
Right. And my question was, I ought to know, but I can't remember what we're allowed to say about osteopathic or chiropractic treatment of headaches in our advertising. It's probably something along the lines of some headaches will respond to, some types of headaches will respond to treatment, do you think we'll be able to convince the ASA that we can be more specific in our marketing from now on about, I say marketing, I mean, informing patients through our websites and other means about what we can treat.

Liz Huzzey
The stuff at the moment is very vague. And the fact is, it's very vague, because there's no definitive science so, we can persuade the ASA to change anything, if we get some robust research. We don't have to persuade them. It's our job, you know, to...

Steven Bruce
Will we have that sort of robustness as a result of this project, do you think?

Liz Huzzey
Well, I think this was the beginning. We get the knowledge out there. So people were doing best for the patients. And then for the people, the osteopaths, chiropractors and physios out there that want to collaborate, you know, we're all probably multi centered, so everybody's got to, if we're going to do any research, it's going to have to be that sort of format, but everybody needs to be speaking the same language. So if we're all going to do a multicentered trial on tension type headaches, then everybody in those centers need to know what the diagnostic criteria for tension type headaches is.

Steven Bruce
We're out of time, in fact we're over time. I'm going to have to stop you there.

Liz Huzzey
Sorry.

Steven Bruce
Thank you so much for coming in.

Liz Huzzey
You're very welcome.

Steven Bruce
And thank you to you and Helena and Vinod, and to Corina for all you're doing at OPHM. It's a great project. Please get involved. And Justin will put up the details again, the e-mail address on the screen while I'm talking. Thank you, Justin, and get involved if you're an osteopath, you can do that. Chiropractors you got a few months to wait to get involved in this, because this is going to be so important in the credibility of our professionals. Anyway, I hope you've enjoyed today's show. I know I have and I'm sure we'll be hearing more from Liz and the team in years and months to come.