

·标准与共识·

偏头痛医疗质量控制指标中国专家共识(第一版)

中国研究型医院学会头痛与感觉障碍专业委员会

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【摘要】 偏头痛是一种常见的失能性疾病,严重影响患者的生活质量。目前,我国在偏头痛的门诊和住院诊疗方面尚缺乏统一的规范和有效的医疗质量控制评价体系。中国研究型医院学会头痛与感觉障碍专业委员会牵头组织全国相关领域的专家,借鉴国内外的研究成果并结合我国头痛医疗体系建设现状和经验,采用改良德尔菲法制定了“偏头痛医疗质量控制指标”体系。该指标体系共包含门诊和住院各 15 项指标以及 2 项附加指标,全面涵盖了接诊、诊断、共病和失能评估、治疗、随访以及智能化辅助工具应用等偏头痛诊疗的全流程。希望该指标体系的建立与实施,为我国偏头痛医疗质量的改进提供依据,并通过持续监测不断提升医务人员对偏头痛的认识,规范临床实践,最终提高偏头痛相关医疗服务的质量。

【关键词】 偏头痛; 质量指标; 卫生保健; 质量控制; 专家共识

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Expert consensus on medical quality control indicators for migraine in China (First Edition)

Chinese Research Hospital Association's Headache and Sensory Disorders Professional Committee

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【Abstract】 Migraine is a common disabling disease that severely affects patients' quality of life. Currently, China lacks a unified standard and an effective medical quality control evaluation system for outpatient and inpatient diagnosis and treatment of migraine. The Professional Committee of Headache and Sensory Disorders of the Chinese Research Hospital Association took the lead in organizing experts in relevant fields across the country. Drawing on domestic and foreign research results, combined with the current situation and experience of China's headache medical system construction, the "Medical Quality Control Indicators for Migraine" system was formulated using the modified Delphi method. The indicator system includes 15 indicators for outpatient and inpatient services respectively, as well as 2 additional indicators, covering the entire process of migraine diagnosis and treatment such as consultation, diagnosis, comorbidity and disability assessment, treatment, follow-up, and application of intelligent auxiliary tools. It is hoped that the establishment and implementation of this indicator system will provide a basis for improving the

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medical quality of migraine in China, continuously enhance medical staff's understanding of migraine through continuous monitoring, standardize clinical practice, and ultimately improve the quality of migraine-related medical services.

【Key words】 Migraine disorders; Quality indicators, health care; Medical quality; Expert consensus

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Migraine is a disabling disease with a high incidence rate. Community epidemiological surveys indicate that the prevalence rate of migraine among adults in China is 9.3%^[1-2]. The 2019 Global Burden of Disease Study showed that migraine is the second leading cause of disability worldwide and the leading cause of disability among women aged 15–49 years^[3]. Migraine not only brings tremendous physical pain to patients, but also significantly affects the quality of life of patients and their families, resulting in substantial social and economic burdens^[4-6]. Health economics research has revealed that the annual medical costs for migraine patients in China are as high as 47.8 billion US dollars, among which the direct costs and indirect costs are 8.4 billion US dollars and 39.4 billion US dollars respectively^[4]. Therefore, migraine has become a public health issue in China that urgently needs to be addressed. Despite the growing attention to the significance of migraine, the level of attention to this disease is still insufficient among both patients and doctors. The existing diagnosis and treatment standards and treatment rates are far from ideal, and there is a lack of full-chain treatment and management strategies. According to data from previous related studies, there are serious problems in the field of migraine diagnosis and treatment in China, such as low diagnostic accuracy, insufficient use of specific analgesics and preventive drugs, inadequate education on related knowledge, insufficient assessment of disability and comorbidities, and improper application of compound preparations containing opioids^[7-10]. It is urgent to establish a standardized diagnosis, treatment and quality control system for migraine to improve the diagnostic accuracy and standardized treatment rate of migraine

in headache centers and headache clinics at all levels, and to improve the prognosis of patients.

Therefore, relying on the national key research and development program "Establishment of Migraine Special Disease Cohort, Clinical Research Platform and Quality Control System", the Professional Committee of Headache and Sensory Disorders of the Chinese Research Hospital Association has screened and established the medical quality control schemes for migraine outpatient and inpatient services through methods such as extensive and systematic literature retrieval, expert interviews, and correspondence consultation. Finally, expert recommendations are put forward to form this consensus, aiming to provide standardized guidance and scientific basis for relevant medical institutions and medical workers, so as to promote high-quality migraine diagnosis and treatment work nationwide.

I. Methods for Developing the Consensus

1. Purpose and Scope of the Consensus: To improve the level of diagnosis and treatment of migraine among clinical physicians in China, and promote the standardization and homogenization of migraine diagnosis and treatment, the Professional Committee of Headache and Sensory Disorders of the Chinese Research Hospital Association initiated and formulated this consensus. This consensus covers 15 indicators for outpatient medical quality control of migraine, 15 indicators for inpatient medical quality control, and 2 additional indicators, including the situation of consultation, diagnosis, comorbidity and disability assessment, treatment, follow-up, and application of intelligent auxiliary tools, covering the entire process of migraine diagnosis and treatment.

2. Initiating and Participating Units of the



Consensus: The formulation of this consensus was initiated by the Professional Committee of Headache and Sensory Disorders of the Chinese Research Hospital Association, with the participation of 50 hospitals including Chinese PLA General Hospital and the First Affiliated Hospital of Xi'an Jiaotong University.

3. Expert Group for Consensus Development: The members of the consensus development and writing group are mainly experts from the Department of Neurology, Medical Faculty of Chinese PLA General Hospital and the Department of Neurology of the First Affiliated Hospital of Xi'an Jiaotong University. Meanwhile, experts from the Department of Neurology and other related disciplines across the country were invited to form a consensus development expert group, including 57 experts in total, such as clinical physicians, methodological experts, and evidence-based medicine experts.

4. Registration and Writing of the Consensus: This consensus has been registered on the Practice Guidelines Registry Platform (<http://www.guidelines-registry.cn>) with the registration number: PREPARE-2025CN148. The expert group conducted an extensive and systematic review of relevant guidelines, systematic reviews, and studies on migraine at home and abroad. Through expert interviews and panel meetings, combined with domestic and foreign research results^[7-15], as well as the current situation of China's medical system and experience in headache management, a questionnaire survey was conducted using the modified Delphi method. The first round of the questionnaire focused on indicators for migraine diagnosis, treatment, and full-course management, inviting experts to put forward opinions and suggestions to form preliminary recommendations. All quality control indicators are not assigned weights for the time being; detailed scoring will be carried out according to different levels of headache centers and headache clinics after subsequent extensive pilot projects and the full implementation of national migraine quality control. After the first

round of review, all members of the expert group conducted in-depth discussions on the indicators with differences and put forward revision opinions. After the second round of questionnaire voting, the final recommendations were determined. Through the above methods, the final draft of this consensus was finally formed.

5. Release, Dissemination, and Update of the Consensus: After the draft consensus was formed, it was finally determined and released after multiple rounds of expert demonstration. The consensus will be mainly disseminate and promote through the following ways: (1) Publishing in relevant academic journals; (2) Conducting consensus interpretations and academic conference lectures in different regions and disciplinary fields in China to enable clinical physicians to fully understand and correctly apply this consensus; (3) Publicizing and promoting through the Internet or other media. After the release of this consensus, it will be continuously updated and improved according to the update of relevant research evidence and its impact on the consensus recommendations, combined with the current situation of clinical diagnosis and treatment, so as to better guide clinical practice and form technical specifications.

II. Medical Quality Control Indicators for Migraine Outpatient Services

(I) Headache Consultation Capacity

Indicator -1: Number of Headache Patient Consultations, ; **Definition:** The total number of outpatient cases where the main complaint is "headache" or similar, or the diagnostic ICD code includes headache/neuralgia, averaged per month.

Calculation Method: The number of headache patient consultations is obtained by extracting medical records with the main complaint keyword "headache" or diagnostic ICD codes including headache or neuralgia.

Significance: The average monthly number of patient consultations is a comprehensive indicator directly reflecting the outpatient diagnosis and treatment capacity, effectiveness, and influence.

(II) Headache Diagnosis Status



Indicator 2: Accuracy Rate of Headache Diagnosis; **Definition:** Experts randomly select outpatient medical records with the main complaint of "headache" or similar, or diagnostic ICD codes including headache/neuralgia. They assess the ability to accurately identify secondary headache patients and the rate of correct diagnosis and differential diagnosis of primary headache patients in accordance with relevant guidelines.

Calculation Formula: Standardized Diagnosis Rate of Headache Patients = $\frac{\sum \text{Number of medical records with correct diagnosis (from randomly selected headache records by experts)}}{\sum \text{Total number of randomly selected outpatient records with "headache" as the main complaint}} \times 100\%$

Significance: It reflects the implementation of standardized diagnosis of headache in medical institutions, helps improve the quality of headache diagnosis and treatment, and provides an objective basis for formulating appropriate treatment plans.

Specific Implementation Methods in Expert Quality Control: The department prepares the medical record system in advance. Experts first select 50 medical records with headache as the main complaint from the past 3 months for a preliminary assessment focusing solely on the "rate of standardized diagnosis among headache patients". Based on this, 20 migraine medical records are further selected for in-depth quality control analysis of the remaining indicators.

Indicator 3: Consultation Rate of Migraine Patients (i.e., Rate of Diagnosed Migraine Cases); **Definition:** The proportion of cases diagnosed as "migraine" among the total number of headache patient consultations within a specific period.

Calculation Formula: Consultation Rate of Migraine Patients = $\frac{\sum \text{Number of cases diagnosed as migraine within a specific period}}{\sum \text{Total number of migraine patient consultations in the same period}} \times 100\%$

Significance: The consultation rate of migraine patients represents the outpatient capacity, effectiveness, and influence in diagnosing and treating migraine patients.

Indicator 4: Rate of Standardized Outpatient Medical Records for Migraine Patients

Definition: The proportion of randomly selected outpatient medical records of "migraine" that are written in accordance with guidelines, as assessed by experts. The content should include at least the frequency, duration, severity, accompanying symptoms, presence of aura, and medication use of headaches.

Calculation Formula: Standardized Documentation Rate of Migraine Medical Records = $\frac{\sum \text{Number of standardized migraine outpatient medical records}}{\sum \text{Total number of randomly selected migraine outpatient medical records by experts}} \times 100\%$

Significance: The quality of outpatient medical record documentation reflects the ability to evaluate migraine patients and may affect the effectiveness of diagnosis and treatment.

(III) Migraine Treatment Status

Indicator 5: Recording Rate of Acute Migraine Medication Use; **Definition:** The proportion of randomly selected outpatient medical records of migraine diagnosis and treatment that document the use of acute-phase medications (including drug type and administration time), as assessed by experts.

Recording Rate of Acute Migraine Medication Use = $\frac{\sum \text{Number of medical records documenting acute-phase medication use}}{\sum \text{Total number of randomly selected migraine outpatient medical records by experts}} \times 100\%$

Significance: Reflects the implementation of standardized diagnosis and treatment measures for migraine in hospitals.

Remarks: The assessment of recorded acute migraine medication use includes drug name, administration route, dosage, frequency, effectiveness, and adverse reactions. According to Chinese Guidelines for Acute Migraine Treatment (First Edition) ^[8], acute-phase treatments may include acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), triptans, calcitonin gene-related peptide (CGRP) receptor antagonists, etc. It should be emphasized that opioids, barbiturates, and caffeine-containing drugs are addictive, may cause medication-overuse headache, and induce resistance to other drugs, so their use must be recorded in detail.

Indicator 6: Application Rate of Specific



Acute Migraine Medications; Definition: The proportion of outpatient migraine medical records (randomly selected by experts) in which specific drugs (triptans, ditans, gepants, etc.) are prescribed or recommended for acute migraine, in accordance with Chinese Guidelines for Migraine Diagnosis and Treatment (2022 Edition)^[9] and Chinese Guidelines for Acute Migraine Treatment (First Edition)^[8].

Calculation Formula: Application Rate of Specific Acute Migraine Medications = $\frac{\Sigma \text{Number of medical records with prescriptions or recommendations for specific acute medications}}{\Sigma \text{Total number of randomly selected migraine outpatient medical records by experts}} \times 100\%$

Significance: Acute migraine medication treatment can be divided into non-specific and specific drugs. Assessing the application rate of specific acute-phase drugs reflects the level of standardized migraine diagnosis and treatment to a certain extent.

Indicator 7: Rate of Prescribing Compound Preparations Containing Addictive Drugs for Migraine Patients; Definition: The proportion of randomly selected outpatient medical records of migraine diagnosis and treatment in which compound preparations containing addictive drugs (opioids, barbiturates, caffeine, etc.) are prescribed, as assessed by experts.

Calculation Formula: Utilization Rate of Compound Preparations of Addictive Drugs for Migraine = $\frac{\Sigma \text{Number of medical records with prescriptions for addictive compound preparations}}{\Sigma \text{Total number of randomly selected migraine outpatient medical records by experts}} \times 100\%$

Significance: Compound preparations containing addictive drugs (opioids, barbiturates, caffeine, etc.) have significant analgesic effects in the short term, but long-term use significantly increases the incidence of medication-overuse headache. This is a negative indicator, reflecting the level of diagnosis and treatment to a certain extent.

Illustration: Barbiturate-containing compound preparations include paracetamol and barbital tablets, new compound indigofera tinctoria tablets, and pain-relieving tablets; opioid-containing

compound preparations include ibuprofen and codeine, paracetamol and codeine, paracetamol and hydrocodone, and codeine; caffeine-containing compound preparations include naoqing tablets, saridon, and headache powder.

Indicator 8: Application Rate of Preventive Medications for Outpatient Migraine Patients

Definition: The proportion of outpatient migraine patients (randomly selected by experts) with indications for preventive medication (in accordance with Chinese Guidelines for Migraine Diagnosis and Treatment (2022 Edition)^[9] who are prescribed preventive medications.

Calculation Formula: Application Rate of Migraine Preventive Medications = $\frac{\Sigma \text{Number of medical records with prescriptions for preventive medications}}{\Sigma \text{Total number of randomly selected migraine outpatient medical records with preventive indications by experts}} \times 100\%$

Significance: For patients with indications for preventive medication, preventive treatment aims to reduce the frequency, duration, and severity of migraine attacks, improve migraine-related disability, enhance quality of life, reduce frequent or chronic headaches, decrease reliance on acute-phase treatments, and prevent medication-overuse headache.

Indicator 9: Notification Rate of Drug Withdrawal for Migraine Patients Complicated with MOH; Definition: The proportion of randomly selected outpatient medical records of migraine patients with MOH (assessed by experts) that contain documentation of drug withdrawal notification (drug withdrawal notification refers to descriptions in medical records related to withdrawal, such as "discontinuation", "abstinence", or "withdrawal" of drugs).

Calculation Formula: Notification Rate of Drug Withdrawal for Migraine Patients with MOH = $\frac{\Sigma \text{Number of medical records with drug withdrawal notification}}{\Sigma \text{Total number of randomly selected medical records of migraine patients with MOH by experts}} \times 100\%$

Significance: This indicator effectively reflects the implementation of standardized headache diagnosis and treatment measures in hospitals, which not only plays a positive role in improving the



treatment effect of chronic migraine but also helps prevent disease recurrence. As a common type of chronic headache^[15-16], MOH is defined in the International Classification of Headache Disorders-3 (ICHD-3) as a condition where patients with primary headache experience ≥ 15 headache days per month and overuse acute or symptomatic headache medications for more than 3 months. For migraine patients, those with MOH are identified based on the frequency of acute-phase medication use, and they should be informed of the drugs to be withdrawn, withdrawal methods, and possible adverse reactions.

(IV) Assessment of Migraine Comorbidities and Disability

Indicator 10: Assessment Rate of Migraine Complicated with Anxiety and Depression; Definition: The proportion of randomly selected first-visit outpatient medical records of migraine patients (assessed by experts) that contain complete evaluations of anxiety and depression.

Calculation Formula: Assessment Rate of Anxiety and Depression in Migraine Patients = $\frac{\sum \text{Number of medical records with assessments of comorbid anxiety and depression}}{\sum \text{Total number of randomly selected first visit migraine outpatient medical records by experts}} \times 100\%$

Significance: Reflects the implementation of standardized headache diagnosis and treatment measures in hospitals. Comorbid anxiety and depression significantly increase the disease burden of migraine patients. Screening for anxiety and depression should be conducted during migraine outpatient assessments. Medical records should document the evaluation of patients' comorbid anxiety and depression. Recommended scales include the Generalized Anxiety Disorder-7 (GAD-7) and the Patient Health Questionnaire-9 (PHQ-9).

Indicator 11: Assessment Rate of Migraine Complicated with Sleep Disorders; Definition: The proportion of randomly selected first-visit outpatient medical records of migraine patients (assessed by experts) that show completion of sleep disorder assessment.

Calculation Formula: Assessment Rate of Migraine Complicated with Sleep Disorders = $\frac{\sum \text{Number of medical records with completed sleep disorder assessment}}{\sum \text{Total number of randomly selected first visit migraine outpatient medical records by experts}} \times 100\%$

Significance: Reflects the implementation of standardized diagnosis and treatment measures for migraine complicated with sleep disorders in medical institutions. It helps improve the timely identification and treatment of migraine comorbid with sleep disorders, thereby enhancing patients' quality of life^[17-19]. The recommended scale is the Pittsburgh Sleep Quality Index (PSQI).

Indicator 12: Assessment Rate of Migraine Disability; Definition: The proportion of randomly selected outpatient medical records of migraine patients (assessed by experts) that show completion of headache disability-related scale screening.

Calculation Formula: Disability Assessment Rate of Migraine Patients = $\frac{\sum \text{Number of medical records with completed headache disability scale screening}}{\sum \text{Total number of randomly selected first visit migraine outpatient medical records by experts}} \times 100\%$

Recommended Scales: The Migraine Disability Assessment Scale (MIDAS) reflects headache burden over the past 3 months. The Headache Impact Test-6 (HIT-6) evaluates the impact of headaches on patients' work, study, family, and social activities within 4 weeks.

(V) Migraine Follow-up Status

Indicator 13: Migraine Follow-up Rate; Definition: The proportion of randomly selected outpatient medical records of migraine patients (assessed by experts) that show the patient had a follow-up visit after the first consultation.

Calculation Formula: Follow-up Rate = $\frac{\sum \text{Number of medical records with follow-up visits after the first outpatient consultation}}{\sum \text{Total number of randomly selected migraine outpatient medical records by experts}} \times 100\%$

Indicator 14: Recording Rate of Migraine Headache Diaries; Definition: The proportion of randomly selected outpatient medical records of migraine patients (assessed by experts) that contain



instructions for patients to record headache diaries in a standardized manner.

Calculation Formula: the Rate of Headache Diaries Recording Among Migraine Patients = $\frac{\Sigma \text{Number of medical records with instructions for migraine patients to record headache diaries}}{\Sigma \text{Total number of randomly selected first-visit migraine outpatient medical records by experts}} \times 100\%$

Significance: Reflects the implementation of standardized headache diagnosis and treatment measures in hospitals, and helps provide detailed medical history to assist in diagnosis and evaluation of the effectiveness of prevention and treatment. Outpatient medical records should reflect the hospital's patient education on the use of headache diaries and the patient's recording of headache diaries. Headache diaries can be in various forms such as paper records and electronic diaries.

Indicator 15: In-hospital Health Education for Migraine; Definition: Conducting no less than 2 types of the following health education contents.

Recording Method: Mark as "Yes/No" for conducting health education.

Main contents include: ① Patient education: forms such as free medical consultations, patient education sessions, publicity boards, and promotional leaflets; ② Continuing education: including headache-related continuing education programs, academic activities, etc.

III. Medical Quality Control Indicators for Migraine Inpatient Services

(I) Consultation Status

Indicator 1: Proportion of Specialized Beds for Headache; Definition: The ratio of the number of open specialized beds for headache to the number of open beds in the Department of Neurology during the same period.

Calculation Formula: Proportion of Specialized Beds for Headache = $\frac{\Sigma \text{Number of open specialized beds for headache}}{\Sigma \text{Number of open beds in the Department of Neurology during the same period}} \times 100\%$

Significance: Reflects the allocation of specialized bed resources for headache.

Indicator 2: Annual Number of Inpatient

Consultations for Headache; Definition: The total number of inpatients with headache admitted to the Department of Neurology within one year.

Significance: Inpatient medical records with the main complaint of "headache" or similar, or with discharge diagnostic ICD codes including headache/neuralgia are selected. The annual number of inpatient consultations directly reflects the diagnosis and treatment capacity, effectiveness, and influence in managing headache disorders.

(II) Diagnosis Status

Indicator 3: Accuracy Rate of Diagnosis for Inpatients with Headache; Definition: The proportion of patients (from randomly selected inpatient medical records by experts) with the main complaint of "headache" or similar, or with diagnostic ICD codes including headache/neuralgia, who are accurately identified as having secondary headache and correctly diagnosed and differentially diagnosed as having primary headache in accordance with relevant guidelines.

Calculation Formula: Standardized Diagnosis Rate for Headache Inpatients = $\frac{\Sigma \text{Number of medical records with correct diagnosis}}{\Sigma \text{Total number of randomly selected inpatient medical records with the main complaint of "headache" by experts}} \times 100\%$

Significance: Reflects the implementation of standardized diagnosis for headache in medical institutions, helping to improve the quality of headache diagnosis and treatment and providing an objective basis for formulating appropriate treatment plans.

Remarks: "Correct diagnosis of headache" refers to: (1) Accurately identifying possible secondary headache and conducting necessary auxiliary examinations; (2) Classifying and differentially diagnosing primary headache in accordance with relevant guidelines.

Indicator 4: Standardized Documentation Rate of Inpatient Medical Records for Migraine Patients; Definition: The proportion of randomly selected inpatient medical records for migraine diagnosis and treatment (assessed by experts) that are documented



in accordance with guidelines. The records should include at least the frequency, duration, severity, accompanying symptoms, presence of aura, medication use, and standardized diagnosis of headaches.

Calculation Formula: Standardized Documentation Rate of Inpatient Medical Records = $\frac{\Sigma \text{Number of migraine inpatient medical records assessed as standardized}}{\Sigma \text{Total number of randomly selected migraine inpatient medical records by experts}} \times 100\%$

Significance: The quality of inpatient medical record documentation represents the ability to evaluate diagnosis and treatment of migraine patients, which may affect the effectiveness of diagnosis and treatment.

Indicator 5: Recording Rate of Acute-Phase Medication Use in Migraine Inpatients; Definition: The proportion of randomly selected inpatient medical records of migraine patients (assessed by experts) that document the use of acute-phase medications within 3 months or during the last 10 episodes.

Calculation Formula: Recording Rate of Acute-Phase Medication Use in Migraine Inpatients = $\frac{\Sigma \text{Number of medical records documenting acute phase medication use}}{\Sigma \text{Total number of randomly selected migraine inpatient medical records by experts}} \times 100\%$

Significance: Reflects the implementation of standardized diagnosis and treatment measures for migraine in hospitals. The records of acute-phase medication use should include drug name, administration route, dosage, frequency, effectiveness, and adverse reactions. Acute-phase treatments may include acetaminophen, NSAIDs, triptans, CGRP receptor antagonists, etc. Drugs such as opioids, barbiturates, and caffeine are addictive, may cause medication-overuse headache, and induce resistance to other drugs, so their use must be recorded in detail.

III. Inpatient Medical Quality Control Indicators for Migraine

(III) Treatment Status

Indicator 6: Application Rate of Acute-Specific Drugs in Inpatients with Migraine; Definition: The proportion of inpatient medical records meeting the

criteria for using acute-specific drugs for migraine, in accordance with Chinese Guidelines for the Diagnosis and Treatment of Migraine (2022 Edition)^[9] and Chinese Guidelines for Acute Treatment of Migraine (First Edition)^[8], among the total sampled migraine medical records.

Calculation Formula: Application Rate of Acute-Specific Drugs = $\frac{\Sigma \text{Number of medical records with acute-specific drug application}}{\Sigma \text{Total number of randomly sampled inpatient medical records of migraine by experts}} \times 100\%$

Significance: The acute drug treatment for migraine can be divided into non-specific drugs and specific drugs. Evaluating the application rate of specific drugs in inpatients can reflect the level of diagnosis and treatment to a certain extent.

Indicator 7: Application Rate of Preventive Drugs in Inpatients with Migraine; Definition: The proportion of medical records, among those randomly sampled by experts from inpatients with migraine, that show patients with indications for preventive drug use have been prescribed such drugs, in accordance with Chinese Guidelines for the Diagnosis and Treatment of Migraine (2022 Edition)^[9].

Calculation Formula: Application Rate of Preventive Drugs in Inpatients with Migraine = $\frac{\Sigma \text{Number of migraine medical records with prescribed preventive drugs}}{\Sigma \text{Number of randomly sampled migraine medical records with indications for prevention by experts}} \times 100\%$

Significance: For patients with indications for preventive drug use, preventive treatment aims to reduce the frequency, duration, and severity of migraine attacks, improve migraine-related disability, enhance quality of life, reduce frequent or chronic headaches, decrease reliance on acute treatment, and avoid the occurrence of medication-overuse headache.

Indicator 8: Notification Rate of Drug Withdrawal for Inpatients with Migraine Complicated by MOH; Definition: The proportion of inpatients with migraine who have completed MOH screening and been informed of the need for drug withdrawal treatment, among the total number of inpatients with migraine complicated by MOH within a specific period.



Calculation Formula: Notification Rate of Drug Withdrawal for Inpatients with Migraine Complicated by MOH = $\frac{\Sigma \text{Number of cases with notification of drug withdrawal}}{\Sigma \text{Total number of inpatients with migraine complicated by MOH per unit time}} \times 100\%$

Significance: This indicator effectively reflects the implementation of standardized diagnosis and treatment measures for headaches in hospitals. It not only plays a positive role in improving the treatment effect of chronic migraine but also helps prevent recurrence. MOH is a common type of chronic headache. According to ICHD-3, MOH is diagnosed when patients with primary headaches have headache attacks for ≥ 15 days per month and have used acute or symptomatic headache medications for more than 3 months. For patients with migraine, those with MOH are identified based on the frequency of acute drug use, and they should be informed of the methods, course of treatment, and possible adverse reactions of drug withdrawal.

Note: Randomly sample a certain number of inpatient medical records with diagnoses including "medication-induced headache" or "medication-overuse headache," and count the number of records with descriptions of notification of drug withdrawal. Notification of drug withdrawal refers to descriptions related to withdrawal in medical records, such as "discontinuation of drugs," "cessation of drugs," "withdrawal of drugs," etc.

Indicator 9: In-Hospital Provision of Relevant Treatments

Definition: For inpatients, at least 2 of the following treatments are provided, including: botulinum toxin therapy, nerve block, non-invasive neuromodulation (including transcranial magnetic stimulation, transcranial direct current stimulation, supraorbital nerve electrical stimulation, vagus nerve electrical stimulation, occipital nerve electrical stimulation, remote nerve electrical stimulation, etc.), biobehavioral therapy (including cognitive behavioral therapy, biofeedback, relaxation therapy, mindfulness meditation therapy, etc.), and acupuncture.

Recording Method: (Yes/No) Whether at least 2

relevant treatments are provided.

Significance: Some alternative treatments can be used as adjuvant therapies to acute and preventive drug treatments, or as standalone therapies when conventional drug treatments are intolerable or contraindicated. Refer to Chinese Guidelines for the Diagnosis and Treatment of Migraine (2022 Edition)^[9] and Chinese Guidelines for Acute Treatment of Migraine (First Edition)^[8].

(IV) Comorbidity and Disability Assessment of Inpatients with Migraine

Indicator 10: Assessment rate of comorbid anxiety and depression in inpatients with migraine;
Definition: The ratio of medical records where inpatients with migraine completed assessments related to anxiety and depression to the total number of randomly selected migraine inpatient medical records by experts.

Calculation formula: Assessment rate of comorbid anxiety and depression in inpatients with migraine = $\frac{\Sigma \text{Number of medical records with completed anxiety and depression evaluation}}{\Sigma \text{Total number of randomly selected migraine inpatient medical records by experts}} \times 100\%$

Significance: Reflects the implementation of standardized diagnosis and treatment measures for headache in the hospital. Comorbid anxiety and depression significantly increase the disease burden of migraine patients. Assessment of anxiety and depression should be conducted during the hospitalization of migraine patients. The medical records should describe the evaluation of patients' comorbid anxiety and depression. Recommended scales include GAD-7, PHQ-9, etc.

Indicator 11: Assessment rate of comorbid sleep disorders in inpatients with migraine;
Definition: The ratio of medical records where inpatients with migraine completed sleep disorder assessment to the total number of randomly selected migraine inpatient medical records by experts during the same period.

Calculation formula: Assessment rate of comorbid sleep disorders = $\frac{\Sigma \text{Number of medical records with completed sleep disorder scale screening}}{\Sigma \text{Total number of randomly selected migraine inpatient medical records by experts}} \times 100\%$



Significance: Reflects the implementation of standardized diagnosis and treatment measures for migraine with comorbid sleep disorders in medical institutions. It helps to improve the timely identification and treatment of migraine with comorbid sleep disorders and enhance patients' quality of life. The recommended scale can be PSQI.

Indicator 12: Disability assessment rate of inpatients with migraine; Definition: The ratio of medical records where inpatients with migraine completed disability assessment to the total number of randomly selected migraine inpatient medical records by experts.

Calculation formula: Disability assessment rate of migraine = $\frac{\Sigma \text{Number of medical records with completed and recorded disability assessment}}{\Sigma \text{Total number of randomly selected migraine inpatient medical records by experts during the same period}} \times 100\%$

Recommended scales: MIDAS reflects the headache burden in the past 3 months. HIT-6 evaluates the impact of headache on patients' work, study, family and social activities within 4 weeks.

(V) Follow-up of Migraine Patients after Discharge

Indicator 13: Follow-up rate of discharged patients with migraine; Definition: The proportion of cases that completed follow-up within the corresponding time after discharge among the randomly selected medical records of discharged migraine patients by experts.

Calculation formula: Follow-up rate = $\frac{\Sigma \text{Number of migraine medical records with completed follow up within the corresponding time after discharge}}{\Sigma \text{Total number of randomly selected medical records of discharged migraine patients by experts}} \times 100\%$

Indicator 14: Headache diary recording rate of inpatients with migraine; Definition: The ratio of migraine patients with standardized headache diary records to the medical records of migraine inpatients admitted during the same period.

Calculation formula: Headache diary recording rate of inpatients with migraine = $\frac{\Sigma \text{Number of medical records with standardized headache diary records}}{\Sigma \text{Total number of randomly selected migraine inpatient medical records by}}$

$\text{experts} \times 100\%$

Significance: Reflects the implementation of standardized diagnosis and treatment measures for headache in the hospital, and helps to provide detailed medical history for diagnosis and evaluation of preventive and therapeutic effects. The medical records of inpatients with migraine should reflect the hospital's education on patients using headache diaries and the status of patients' headache diary records. Headache diaries can be in various forms such as paper records and electronic diaries.

Indicator 15: Health education for migraine patients during hospitalization; Definition: Carry out no less than 2 of the following educational contents.

Recording method: (Yes/No) Carry out no less than 2 related educational contents.

Main educational contents include: ① Patient education: in the forms of patient education, publicity boards, publicity leaflets, official WeChat accounts, media, etc.; ② Continuing education: including headache continuing education programs, academic activities, etc.

IV. Additional Indicators

Application of the intelligent auxiliary tool for headache – Clinical Decision Support System (CDSS).

Indicator 1: Headache CDSS Entry Rate; Definition: The ratio of the number of headache patients entered into CDSS within a unit time to the total number of headache patients treated in the headache clinic of the same unit during the same period.

Calculation Formula: Headache Patient CDSS Entry Rate = $\frac{\Sigma \text{Number of headache patients entered into CDSS within a unit time}}{\Sigma \text{Total number of headache patients treated in the headache clinic of the unit during the same period}} \times 100\%$

Indicator 2: Migraine CDSS Diagnosis Confirmation Rate; Definition: The ratio of the number of patients confirmed as having migraine by physicians through CDSS within a unit time to the total number of patients diagnosed as having migraine in the headache clinic of the same unit during the same



period.

Calculation Formula: CDSS Migraine Confirmation Rate = $\frac{\Sigma \text{Number of cases confirmed as migraine by physicians in CDSS within a unit time}}{\Sigma \text{Total number of migraine patients in the headache clinic of the unit during the same period}} \times 100\%$

Remarks: The confirmation of migraine in CDSS should be specified to the secondary diagnosis, such as migraine without aura, migraine with aura, probable migraine, and chronic migraine, etc.

Significance: To help clinicians effectively improve the accuracy of headache diagnosis, the PLA General Hospital took the lead in developing the Headache Clinical Decision Support System, an intelligent auxiliary diagnostic tool specifically for headache disorders. At present, both the standalone and networked versions of CDSS can achieve satisfactory diagnostic accuracy for migraine^[20-22], and can accurately differentiate probable migraine from probable tension-type headache^[23]. By applying this intelligent auxiliary tool in the diagnosis and treatment process, physicians can not only further familiarize themselves with the inquiry path of headache disorders and the diagnostic criteria of ICHD-3, but also imperceptibly improve their diagnostic ability for primary headaches, thereby comprehensively enhancing the standardized diagnosis and treatment level of migraine^[24].

V. Summary

This consensus is the first expert consensus in China on the medical quality control of outpatients and inpatients with migraine. It was formulated using the Delphi method, organizing experts in relevant fields across the country to conduct research and demonstration, and formed after multiple rounds of discussions and repeated revisions, ensuring the organic combination of scientificity and practical adaptability of the content. It aims to promote the standardized diagnosis and treatment of migraine and provide a scientific basis for the formulation of relevant health policies. At present, the medical quality control

of migraine in China is still in its initial stage, and continuous exploration and improvement are needed to formulate more comprehensive and perfect treatment and management strategies. The core content of this consensus covers 15 quality control indicators for outpatient and inpatient diagnosis and treatment respectively, constructing an evaluation system covering the entire chain of "consultation – diagnosis – treatment – follow-up". In addition, the consensus introduces the application of CDSS into additional indicators, with a view to assisting physicians in improving diagnostic accuracy and consensus compliance through intelligent tools. The editorial team hopes that the release of this consensus can better help medical institutions and health service personnel deeply understand the norms and standards of outpatient and inpatient diagnosis and treatment of migraine. In the later stage, different quality control standards will be formulated according to the differences in medical environments in different regions and combined with local actual conditions, and effectively applied to clinical practice. Finally, through multi-party cooperation and dynamic optimization, the standardization and homogenization of migraine diagnosis and treatment will be realized, the disease burden of patients will be effectively reduced, and the implementation of the "Healthy China" strategy will be facilitated.

Declaration: This consensus was led and formulated by the Headache and Sensory Disorders Professional Committee of the Chinese Research Hospital Association. It is based on the guiding principles of evidence-based medicine, combined with the opinions of experts from many hospitals across the country, and invited multidisciplinary experts for demonstration and final approval. Inevitably, there are some deficiencies in this version of the consensus. We sincerely welcome users to provide valuable suggestions and opinions for improvement in the new version. In addition, we solemnly declare that the views in this consensus shall not be used for commercial promotion and publicity.



偏头痛是一种高发病率的失能性疾病,社区流行病学调查提示我国成年人偏头痛患病率为 9.3%^[1-2]。2019 年全球疾病负担研究显示偏头痛是全球第二大致残原因,也是 15~49 岁女性首位致残原因^[3]。偏头痛不仅给患者带来了巨大的身体痛苦,还显著影响患者及其家庭的生活质量、产生重大的社会和经济负担^[4-6]。卫生经济学研究显示,中国偏头痛患者医疗费用高达 478 亿美元/年,其中直接成本和间接成本分别高达 84 亿美元和 394 亿美元^[4]。因此,偏头痛已成为我国一个亟待解决的公共卫生问题。尽管偏头痛的重要性日益受到关注,但在患者和医师层面,对该疾病的关注度仍然不足。现有的诊疗规范和治疗率远未达到理想状态,缺乏全链条的治疗和管理策略。根据以往的相关研究数据,我国偏头痛诊疗领域存在诊断准确率低、特异性止痛药和预防性药物使用不足、相关知识教育力度不够、失能和共病评估不充分、含阿片类复方制剂应用不当等严重问题^[7-10],迫切需要建立偏头痛的规范化诊疗及质量控制体系,以提高各级头痛中心及头痛门诊对偏头痛的诊断准确率和规范治疗率、改善患者的预后。因此,中国研究型医院学会头痛与感觉障碍专业委员会依托国家重点研发计划“偏头痛专病队列及临床研究平台与质量控制体系建立”项目,通过广泛系统地检索相关文献、专家访谈、函询等方法筛选和确立了偏头痛门诊及住院的医疗质量控制方案,最后提出专家推荐意见形成本共识,旨在为相关医疗机构及医务工作者提供规范指导和科学依据,以推动全国范围高质量的偏头痛诊疗工作。

一、共识制定方法

1. 共识的目的和涵盖范围:为提高我国临床医师偏头痛诊治水平,促进偏头痛诊疗的标准化及同质化,中国研究型医院学会头痛与感觉障碍专业委员会发起并制订本共识。本共识涵盖了偏头痛门诊医疗质量控制的 15 项指标、住院医疗质量控制的 15 项指标以及 2 项附加指标,包括接诊情况、诊断、共病和失能评估、治疗、随访以及智能化辅助工具应用等,覆盖偏头痛诊疗的全流程。

2. 共识发起和参与单位:本共识制订由中国研究型医院学会头痛与感觉障碍专业委员会发起,中国人民解放军总医院、西安交通大学第一附属医院等 50 家医院参与。

3. 共识制定专家组:共识制定及编写组成员以中国人民解放军总医院神经内科医学部及西安交通大学第一附属医院神经内科专家为主,同时邀请来自全国各地的神经内科及其他相关学科专家成立共识制定专家组,包括临床医师、方法学专家、循证医学专家共 57 名。

4. 共识的注册与撰写:本共识已在实践指南注册平台(<http://www.guidelines-registry.cn>)进行注册(注册号:PREPARE-2025CN148)。专家组对国内外关于偏头痛的相关指南、系统评价及研究进行了广泛且系统的回顾,通过专家访谈和专家小组会议,结合国内外的研究成果^[7-15]与我国实际的医疗体系现状和头痛管理经验,采用改良德尔菲法进行问卷调查。第一轮问卷围绕偏头痛的诊断、治疗和全程管理指标,邀请专家提出意见和建议,形成初步推荐。所有的质控指标暂不赋予权重,待后续广泛试点以及全国范围的偏头痛质控全面推开后,再根据不同级别的头痛中心和头痛门诊进行详细赋分。在第一轮评审后,专家组全体成员针对存在分歧的指标进行了深入讨论,并提出修订意见。经过第二轮问卷投票,最终确定推荐意见。通过上述方法,最终形成了本共识的终稿。

5. 共识的发布、传播与更新:共识草案形成后,经多轮专家论证,最终确定并发布。共识将主要通过以下方式传播与推广:(1)在相关学术期刊发表;(2)在国内不同地区、不同学科领域进行共识解读与学术会议宣讲,以便临床医师充分了解并正确应用本共识;(3)通过网络或其他媒体宣传推广。本共识发布后,将根据相关研究证据的更新及其对共识推荐意见的反映,并结合临床诊疗现状不断更新完善,以更好地指导临床实践并形成技术规范。

二、偏头痛门诊医疗质量控制指标

(一)头痛接诊能力

指标 1:头痛患者接诊量,定义:平均每月门诊

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中国研究型医院学会
CRHA

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以“头痛或头疼”等为主诉或诊断 ICD 编码,包括头痛或神经痛的患者例次的总和。

计算方式:通过提取门诊病历主诉关键词“头痛或头疼”或诊断 ICD 编码包括头痛或神经痛等获取头痛患者接诊量。

意义:平均每个月接诊患者数量是直接反映门诊诊疗能力、效果及影响力的综合指标。

(二)头痛诊断情况

指标 2:头痛患者诊断正确率,定义:专家随机抽查“头痛或头疼”等为主诉或诊断 ICD 编码包括头痛或神经痛的门诊病历,专家评估继发性头痛患者准确识别能力,根据相应指南对原发性头痛患者进行正确诊断与鉴别诊断的比率。

计算公式:头痛患者规范诊断率= Σ 专家随机抽查的头痛病历中符合正确诊断的病历数/ Σ 专家随机抽查的“头痛”等主诉的门诊病历数 $\times 100\%$

意义:反映医疗机构对头痛规范性诊断的执行情况,有助于提高头痛诊疗质量,并为制订适宜的治疗方案提供客观依据。

专家质控过程中具体实施办法:科室预先准备病案系统,专家首先抽取过去 3 个月内以头痛为主诉的病历 50 份,仅针对“头痛患者规范诊断率”开展初步评估;基于此,再筛选 20 份偏头痛病历,用于以下其余指标深度质控分析。

指标 3:偏头痛患者接诊率既诊断偏头痛的比率,定义:单位时间内,诊断“偏头痛”患者的例次占同期头痛患者接诊量的比率。

计算公式:偏头痛患者接诊率= Σ 单位时间内诊断为偏头痛患者的病例数/ Σ 同期偏头痛患者接诊病例数 $\times 100\%$

意义:偏头痛患者接诊率代表了门诊对偏头痛患者的诊疗能力、效果及影响力。

指标 4:偏头痛患者门诊规范病案率,定义:专家随机抽查“偏头痛”门诊病历中,根据指南进行规范书写的病历数所占比率。内容至少包括头痛发病频率、持续时间、严重程度、伴随症状、有无先兆、用药情况等。

计算公式:偏头痛患者病历规范书写率= Σ 进行规范书写的偏头痛门诊病历数/ Σ 专家随机抽查的偏头痛门诊病历数 $\times 100\%$

意义:门诊病历书写质量代表对偏头痛患者的评估能力,可影响诊疗效果。

(三)偏头痛治疗情况

指标 5:偏头痛急性期药物使用情况记录率,定义:专家随机抽查偏头痛诊疗门诊病历中,记录

急性期药物使用情况(包括药物类型、使用时间)的病历所占比率。

计算公式:偏头痛急性期药物使用情况记录率= Σ 记录急性期药物使用情况的病历数/ Σ 专家随机抽查的偏头痛门诊病历数 $\times 100\%$

意义:反映医院对于偏头痛规范性诊疗措施的执行情况。

备注:评估偏头痛急性期药物使用情况记录包括药物名称、给药方式、剂量、频率、有效性及不良反应。依据《中国偏头痛急性期治疗指南》(第一版)^[8],急性期治疗可使用对乙酰氨基酚、非甾体抗炎药(NSAIDs)、曲坦类药物、降钙素基因相关肽(CGRP)受体拮抗剂等。需要着重说明的是,阿片类、巴比妥类、含咖啡因药物具有成瘾性,可导致药物过度使用性头痛并诱发对其他药物的耐药性,则需要详细记录使用情况。

指标 6:偏头痛急性期特异性药物的应用率,定义:专家随机抽查偏头痛门诊病历,依据《中国偏头痛诊治指南(2022 版)》^[9]及《中国偏头痛急性期治疗指南(第一版)》^[8],偏头痛急性期门诊患者处方或建议使用特异性药物(曲坦类、地坦类、吉泮类等)所占的比率。

计算公式:偏头痛急性期特异性药物应用率= Σ 偏头痛患者处方或建议使用特异性药物的病历数/ Σ 专家随机抽查的偏头痛门诊病历数 $\times 100\%$

意义:偏头痛急性期药物治疗可以分为非特异性药物和特异性药物,评估急性期特异性药物应用率可在一定程度上反映偏头痛规范诊疗水平。

指标 7:偏头痛患者处方含成瘾药物复方制剂的比率,定义:专家随机抽查偏头痛诊疗门诊病历中,处方含成瘾性药物(阿片类、巴比妥类、咖啡因等)复方制剂的病历数的占比。

计算公式:偏头痛成瘾性药物复方制剂的应用率= Σ 抽查处方中含成瘾性药物复方制剂的病历数/ Σ 专家随机抽查的偏头痛门诊病历数 $\times 100\%$

意义:含成瘾性药物(阿片类、巴比妥类、咖啡因等)的复方制剂,短期应用止痛效果显著,但长期应用会明显增加药物过度使用性头痛的发生率。该指标属于负性指标,一定程度上反映了诊疗水平。

说明:含巴比妥复方制剂包括氨酚巴比妥片、新复方大青叶片、去痛片等;含阿片复方制剂包括洛芬待因、氨酚待因、氨酚氢可酮、可待因等;含咖啡因复方制剂包括脑清片、散利痛、头痛粉等。



指标 8: 偏头痛门诊患者预防性药物的应用率, 定义: 专家随机抽查偏头痛门诊病历中, 依据《中国偏头痛诊治指南(2022 版)》^[9]有预防性药物应用指征的患者, 给予预防性药物应用的偏头痛门诊患者的比率。

计算公式: 偏头痛预防性药物的应用率 = Σ 偏头痛患者处方有预防性药物的病历数 / Σ 专家随机抽查有预防指征的偏头痛门诊病历数 $\times 100\%$

意义: 对于有预防性药物应用指征的患者, 预防性治疗旨在降低偏头痛发作的频率、持续时间及严重程度, 改善偏头痛相关性失能, 提高生活质量、减少频繁或慢性头痛, 并减少对急性期治疗的依赖, 避免药物过度使用性头痛的发生。

指标 9: 偏头痛合并药物过度使用性头痛 (medication-overuse headache, MOH) 患者药物戒断告知率, 定义: 专家随机抽查偏头痛门诊病历中, 合并有 MOH 的患者病历中有药物戒断告知内容的病历比率 (药物戒断告知是指: 在病历中有戒断告知相关描述, 如“停药、戒药、撤药”等)。

计算公式: 偏头痛合并 MOH 患者药物戒断告知率 = Σ 有药物戒断告知的病历数 / Σ 专家随机抽查的偏头痛合并 MOH 患者的病历数 $\times 100\%$

意义: 该指标能够有效体现医院在头痛规范化诊疗措施上的落实程度, 不仅对提高慢性偏头痛的治疗效果有积极作用, 还能预防疾病复发。MOH 作为慢性头痛的一种常见类型^[15-16], 在国际头痛分类标准-3 (ICHD-3) 中, 将原发性头痛患者每月头痛发作的时间 ≥ 15 d, 且过度使用急性或症状性头痛治疗药物 3 个月以上, 诊断为 MOH。对于偏头痛患者, 依据急性期药物的用药频率, 筛选出 MOH 的患者, 告知需要戒断的药物、戒断方式以及可能出现的不良反应等。

(四) 偏头痛共病及失能的评估

指标 10: 偏头痛合并焦虑、抑郁的评估率, 定义: 专家随机抽查偏头痛门诊病历中, 首诊偏头痛患者有完善焦虑、抑郁评估内容病历所占比率。

计算公式: 偏头痛患者焦虑、抑郁评估率 = Σ 有共病焦虑、抑郁评估内容的病历数 / Σ 专家随机抽查的首诊偏头痛门诊病历数 $\times 100\%$

意义: 反映医院对于头痛规范化诊疗措施的执行情况。共病焦虑、抑郁状态显著增加了偏头痛患者的疾病负担。偏头痛门诊评估期间应进行焦虑抑郁状态筛查。在病历中应描述对患者共病焦虑、抑郁状态的评估情况。推荐量表包括广泛性焦虑量表 (generalized anxiety disorder-7, GAD-7)、

PHQ-9 健康问卷 (patient health questionnaire-9, PHQ-9) 等。

指标 11: 偏头痛合并睡眠障碍的评估率, 定义: 专家随机抽查偏头痛门诊病历中, 显示首诊完成睡眠障碍评估的病历数占抽查病历数的比率。

计算公式: 偏头痛共病睡眠障碍评估率 = Σ 显示完成睡眠障碍评估的病历数 / Σ 专家随机抽查的首诊偏头痛门诊病历数 $\times 100\%$

意义: 反应医疗机构对偏头痛合并睡眠障碍规范化诊疗措施执行情况。有助于提高对偏头痛共病睡眠障碍的及时识别和治疗, 提高患者生活质量^[17-19]。推荐使用量表可采用匹兹堡睡眠质量指数 (Pittsburgh sleep quality index, PSQI)。

指标 12: 偏头痛失能评估率, 定义: 专家随机抽查偏头痛门诊病历中, 显示完成头痛失能相关量表筛查的病历数占抽查的门诊病历数的比率。

计算公式: 偏头痛患者失能评估率 = Σ 显示完成头痛失能量表筛查的病历数 / Σ 专家随机抽查的首诊偏头痛门诊病历数 $\times 100\%$

推荐量表: 偏头痛失能程度评估问卷 (MIDAS) 反映近 3 个月的头痛负担。头痛影响测验 (HIT-6) 评价 4 周内头痛对患者工作、学习、家庭和社会活动的影响。

(五) 偏头痛随访情况

指标 13: 偏头痛随访率, 定义: 专家随机抽查偏头痛门诊病历中, 显示患者首次就诊后复诊的病历数占抽查门诊病历的比率。

计算公式: 随访率 = Σ 显示门诊首诊后进行随访的病历数 / Σ 专家随机抽查的偏头痛门诊病历数 $\times 100\%$

指标 14: 偏头痛患者头痛日记记录率, 定义: 专家随机抽查的偏头痛门诊病历中, 有告知患者规范记录头痛日记内容病历数占抽查病历数的比率。

计算公式: 偏头痛患者头痛日记记录率 = Σ 告知偏头痛患者记录头痛日记的病历数 / Σ 专家随机抽查的首诊偏头痛门诊病历数 $\times 100\%$

意义: 反映医院对于头痛规范化诊疗措施的执行情况, 有助于提供详细的病史以帮助诊断和评估预防、治疗效果。门诊患者病历应体现医院对使用头痛日记的患者教育及患者头痛日记记录的情况, 头痛日记的形式可为纸质记录、电子日记等多种形式。

指标 15: 偏头痛院内开展宣教, 定义: 开展以下宣教内容不少于 2 种。



记录方式:(是/否)开展宣教。主要包括:①患者教育:包括义诊、患者宣教、宣传展板、宣传折页等形式;②继续教育:包括头痛继续教育项目、学术活动等。

三、偏头痛住院医疗质量控制指标

(一)就诊情况

指标 1:头痛专病床位占比,定义:头痛专病开放床位数占同期神经内科开放床位数的比率。

计算公式:头痛专病床位占比= $\frac{\Sigma \text{头痛专病开放床位数}}{\Sigma \text{同期神经内科开放床位数}} \times 100\%$

意义:反映头痛专科床位资源配置情况。

指标 2:头痛住院患者年接诊量,定义:1 年时间内,神经内科接诊头痛患者住院人数总和。

意义:抽取的神经内科“头痛、头疼”为主诉或出院诊断 ICD 编码包括头痛或神经痛的住院病历,住院患者年接诊数量是直接反映头痛疾患的诊疗能力、效果及影响力的综合指标。

(二)诊断情况

指标 3:头痛住院患者正确诊断率,定义:专家随机抽查的住院病历中以“头痛或头疼”为主诉或诊断 ICD 编码包括头痛或神经痛的患者中,专家评估继发性头痛患者准确识别、原发性头痛患者根据相应指南正确诊断与鉴别诊断的患者例数占比。

计算公式:头痛患者规范诊断率= $\frac{\Sigma \text{显示诊断正确的病历数}}{\Sigma \text{专家随机抽查的以“头痛或头疼”为主诉的住院病历数}} \times 100\%$

意义:反映医疗机构对头痛规范性诊断的执行情况,有助于提高头痛诊疗质量,并为制订适宜的治疗方案提供客观依据。

备注:“头痛正确诊断”是指:(1)准确识别可能的继发性头痛并予以必要的辅助检查;(2)根据相应指南对原发性头痛进行诊断分类与鉴别诊断。

指标 4:偏头痛患者住院病历规范书写率,定义:专家随机抽查“偏头痛”诊疗住院病历,其中根据指南进行规范书写病历占比。至少包括头痛发病频率、持续时间、严重程度、伴随症状、有无先兆、用药情况、规范诊断等。

计算公式:住院病历规范书写率= $\frac{\Sigma \text{评估为规范书写的偏头痛住院病历数}}{\Sigma \text{专家随机抽查的偏头痛住院病历数}} \times 100\%$

意义:住院病历书写质量代表对偏头痛患者的诊疗评估能力,可能影响诊疗效果。

指标 5:偏头痛住院患者急性期药物使用情况记录率,定义:专家随机抽查偏头痛患者住院病历,病历中记录了 3 个月内或最近 10 次发作中使用急性期药物的病历数占抽查病历数的比率。

计算公式:偏头痛急性期药物使用情况记录率= $\frac{\Sigma \text{记录急性期药物使用情况的病历数}}{\Sigma \text{专家随机抽查的偏头痛住院病历数}} \times 100\%$

意义:反映医院对于偏头痛规范性诊疗措施的执行情况。急性期治疗药物使用情况包括药物名称、给药方式、剂量、频率、有效性及不良反应。急性期治疗可使用对乙酰氨基酚、NSAIDs、曲坦类药物、CGRP 受体拮抗剂等。阿片类、巴比妥类、咖啡因等药物具有成瘾性,可导致药物过度使用性头痛并诱发对其他药物的耐药性,需要详细记录使用情况。

(三)治疗情况

指标 6:偏头痛住院患者急性期特异性药物的应用率,定义:依据《中国偏头痛诊治指南(2022 版)》^[9]及《中国偏头痛急性期治疗指南(第一版)》^[8],符合偏头痛急性期特异性药物应用标准的住院病历数占抽查的偏头痛病历总数的比率。

计算公式:急性期特异性药物应用率= $\frac{\Sigma \text{应用急性期特异性药物的病历数}}{\Sigma \text{专家随机抽查的偏头痛住院病历数}} \times 100\%$

意义:偏头痛急性期药物治疗可以分为非特异性药物和特异性药物,评估住院患者特异性药物的应用率可一定程度的反应诊疗水平。

指标 7:偏头痛住院患者预防性药物的应用率,定义:依据《中国偏头痛诊治指南(2022 版)》^[9],专家随机抽取的偏头疼住院患者病历中,显示有预防性药物应用指征且给予预防性药物的病历的占比。

计算公式:偏头痛住院患者预防性药物使用率= $\frac{\Sigma \text{处方有预防性药物的偏头痛病历数}}{\Sigma \text{专家随机抽查有预防指征的偏头痛病历数}} \times 100\%$

意义:有预防性药物应用指征的患者,预防性治疗旨在降低偏头痛发作的频率、持续时间及严重程度,改善偏头痛相关性失能、提高生活质量、减少频繁或慢性头痛,并减少对急性期治疗的依赖,避免药物过度使用性头痛的发生。

指标 8:偏头痛住院患者合并 MOH 者药物戒断告知率,定义:单位时间内,偏头痛住院患者完成 MOH 筛查并告知需要药物戒断治疗例数占偏头痛合并 MOH 总例数的比率。



计算公式:偏头痛合并 MOH 住院患者药物戒断告知率=Σ有药物戒断告知的病例数/Σ单位时间内偏头痛合并 MOH 住院病例总数×100%

意义:该指标能够有效体现医院在头痛规范化诊疗措施上的落实程度,不仅对提高慢性偏头痛的治疗效果有积极作用,还能防范病情复发。MOH 作为慢性头痛的一种常见类型,在 ICHD-3 中,将原发性头痛患者每月头痛发作的时间≥15 d,且使用急性或症状性头痛治疗药物 3 个月以上,诊断为 MOH。对于偏头痛患者,依据急性期药物的用药频率,筛选出 MOH 患者,告知需要戒断的方式、疗程以及可能出现的不良反应等。

说明:随机抽查一定数量诊断包含“药物性头痛”或“药物过度使用性头痛”的住院病历,统计有药物戒断告知描述的病历数。药物戒断告知是指:在病历书写中有戒断告知相关描述,如“停药、戒药、撤药”等。

指标 9:院内开展相关治疗,定义:在住院患者中,开展以下治疗不少于 2 项,包括肉毒素治疗、神经阻滞、无创神经调控(包括经颅磁刺激、经颅直流电刺激、眶上神经电刺激、迷走神经电刺激、枕神经电刺激、远程神经电刺激等)、生物行为疗法(包括认知行为疗法、生物反馈、放松疗法、正念冥想疗法等)、针灸等。

记录方式:(是/否)开展相关治疗不少于 2 项。

意义:部分替代治疗既可作为急性期和预防性药物治疗的辅助疗法,也可在常规药物治疗不耐受或存在药物禁忌时单独应用。参见《中国偏头痛诊治指南(2022 年版)》^[9]及《中国偏头痛急性期治疗指南(第一版)》^[8]。

(四)偏头痛住院患者共病及失能评估

指标 10:偏头痛住院患者合并焦虑、抑郁的评估率,定义:偏头痛住院患者完成焦虑、抑郁相关评估的病历数占专家随机抽查偏头痛住院病历数的比率。

计算公式:偏头痛住院患者合并焦虑、抑郁状态评估率=Σ完成焦虑、抑郁评估的病历数/Σ专家随机抽查的偏头痛住院病历数×100%

意义:反映医院对于头痛规范化诊疗措施的执行情况。共病焦虑、抑郁状态显著增加了偏头痛患者的疾病负担。偏头痛住院评估期间应进行焦虑、抑郁状态筛查。在病历中应对描述患者共病焦虑、

抑郁状态进行评估。推荐量表包括 GAD-7、PHQ-9 等。

指标 11:偏头痛住院患者合并睡眠障碍评估率,定义:完成患者睡眠障碍评估的病历数占同期专家随机抽查的偏头痛住院病历数的比率。

计算公式:共病睡眠障碍评估率=Σ完成睡眠障碍量表评估的病历数/Σ专家随机抽查的偏头痛住院病历数×100%

意义:反应医疗机构对偏头痛共病睡眠障碍规范化诊疗措施执行情况。有助于提高对偏头痛共病睡眠障碍的及时识别及治疗,提高患者生活质量。建议量表可采用 PSQI。

指标 12:偏头痛住院患者失能评估率,定义:偏头痛住院患者进行失能评估的病历数占专家随机抽查的偏头痛住院病历数的比率。

计算公式:偏头痛失能评估率=Σ完成并记录失能评估的病历数/Σ同期专家随机抽查的偏头痛住院病历数×100%

推荐量表:MIDAS 反映近 3 个月的头痛负担。HIT-6 评价 4 周内头痛对患者工作、学习、家庭和社会活动的影响。

(五)偏头痛患者出院后随访情况

指标 13:偏头痛出院患者随访率,定义:专家随机抽查的偏头痛出院病历中,出院后相应时间内有随访的病历数占比。

计算公式:随访率=Σ出院后相应时间内有随访的偏头痛病历数/Σ专家随机抽查的偏头痛出院病历总数×100%

指标 14:偏头痛住院患者头痛日记记录率,定义:规范记录头痛日记的偏头痛病历数占同期收治住院的偏头痛患者病历的比率。

计算公式:偏头痛住院患者头痛日记记录率=Σ规范记录头痛日记的病历数/Σ专家随机抽查的偏头痛住院病历数×100%

意义:反映医院对于头痛规范化诊疗措施的执行情况,有助于提供详细的病史以帮助诊断和评估预防、治疗效果。偏头痛住院患者病历应体现医院对使用头痛日记的患者教育及患者头痛日记记录的情况,头痛日记的形式可为纸质记录、电子日记等多种形式。

指标 15:偏头痛患者住院期间开展宣教,定义:开展以下宣教内容不少于 2 项。

记录方式:(是/否)开展宣教。

宣教内容主要包括:①患者教育:患者宣教、宣传展板、宣传折页、公众号、媒体等形式;②继续教育:包括头痛继续教育项目、学术活动等。



四、附加指标

智能化辅助工具头痛临床决策支持系统(clinical decision support system, CDSS)应用情况。

指标 1: 头痛 CDSS 录入率, 定义: 单位时间内, CDSS 录入头痛患者例数占同期该单位头痛门诊头痛患者接诊总例数的比率。

计算公式: 头痛患者 CDSS 录入率 = $\frac{\Sigma \text{单位时间内录入 CDSS 的头痛患者例数}}{\Sigma \text{同期该单位头痛门诊接诊头痛患者总例数}} \times 100\%$

指标 2: 偏头痛 CDSS 诊断确认率, 定义: 单位时间内 CDSS 医师端确认诊断为偏头痛的患者例数, 占同期该单位头痛门诊中诊断为偏头痛患者总例数的比率。

计算公式: CDSS 偏头痛确认诊断率 = $\frac{\Sigma \text{单位时间内医师在 CDSS 中确认诊断为偏头痛的例数}}{\Sigma \text{同期该单位头痛门诊偏头痛患者的总例数}} \times 100\%$

备注: CDSS 中偏头痛的确认诊断需明确至二级诊断, 如无先兆偏头痛、先兆偏头痛、很可能的偏头痛以及慢性偏头痛等。

意义: 为了帮助临床医师有效提高头痛诊断正确率, 解放军总医院牵头开发了专门针对头痛疾患的智能化辅助诊断工具头痛临床决策支持系统。目前 CDSS 单机版及联网版对偏头痛均能够达到满意的诊断正确率^[20-22], 并且能够对很可能的偏头痛及很可能的紧张型头痛加以精准鉴别^[23]。通过在诊疗过程中应用这一智能化的辅助工具, 医师不仅能够进一步熟悉头痛疾患的问诊路径以及 ICHD-3 的诊断标准, 在潜移默化中提高对原发性头痛的诊断能力, 进而全面提升偏头痛规范化诊疗水平^[24]。

五、总结

本共识是我国首部关于偏头痛门诊和住院患者医疗质量控制的专家共识, 其制订采用德尔菲法, 组织全国相关领域专家进行调研论证, 经过多轮讨论及反复修改而形成, 保证内容科学性与实践适应性的有机结合, 旨在推动偏头痛的规范化诊疗, 为相关卫生政策的制定提供科学依据。目前我国偏头痛的医疗质量控制还处于起步阶段, 尚需要持续探索与改进, 才能制订更全面、完善的治疗管理策略。本共识的核心内容涵盖了门诊与住院诊疗各 15 项质量控制指标, 构建覆盖“就诊—诊断—治疗—随访”全链条的评估体系。此外, 该共识将 CDSS 的应用引入附加指标, 以期通过智能化工具辅助医师提升诊断准确性和共识依从

性。编写组希望本共识的发布可以更好地帮助医疗机构和卫生服务人员深入了解偏头痛门诊和住院诊疗的规范和标准, 后期也将根据不同地区医疗环境的差异, 结合地方实际情况制定不同的质量控制标准, 并将其有效地运用于临床实践, 最终通过多方协作与动态优化, 实现偏头痛诊疗的标准化与同质化, 切实减轻患者疾病负担, 助力“健康中国”战略的实施。

本共识由中国研究型医院学会头痛与感觉障碍专业委员会牵头制订。它基于循证医学的指导原则, 结合了来自全国多家医院专家的意见, 并邀请了多学科专家进行论证和最终审定。本版共识不可避免地存在一些不足之处, 我们诚挚欢迎使用者提供宝贵的建议和意见, 以便在新版中进行改进。

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《中国研究型医院(中英文)》杂志的栏目和内容设置要求

研究型医院专栏：包括研究型医院理论、人才、医院建设、运行模式探索（研究型医院现代管理理论、技术、方法探讨，人力资源、医疗质量、护理、教学、医技科室管理、产业研究、药品与设备监管、医疗保障、财务管理、科研管理等）；医院经济学例如医院运营成本和收益、不同病种和治疗方法、诊疗模式的费用探讨和医学转化的相关研究；医药卫生体制改革、政策落地效果、现代医院管理制度等方面的研究。

临床医学研究：能体现研究型医院特色，针对临床工作中的疑难问题进行的研究；罕见病研究（难病聚焦），医疗新技术与新方法的研究。

医学实验研究：基础医学研究内容。

研究快讯：以摘要的形式报道前沿的、创新性的临床和基础研究的初步成果；简要介绍新产品的用途、用法，新药物的适应证、禁忌证、治疗方案等信息。

综述：对特定医学主题的深入综合分析和总结，以帮助同行了解最新的研究和进展。

专家有约：约请专家撰稿，分享自己的见解、经验和观点，以促进专业交流和知识传播。

述评：对某时期某学科或某专题所发表的原始文献中有价值的内容进行综述和评论。

标准与共识：相关领域的知名专家就特定领域的标准和共识达成一致意见，以指导临床实践和研究方向。

名家解惑：知名专家对医学领域热点和难点问题的解答。

热点追踪：对国家重点关注的专业研究热点的系列报道。

国际视野：报道国际研究动态。

争鸣园地：同一话题的不同观点的文章，进行学术讨论。

读者·作者·编者：包括读者来信、作者的感言以及编辑部的消息，用于与刊物的读者和作者互动和交流。

消息：医学界的新闻、通知和重要事件的报道，以保持医学专业人士和研究者的信息更新。

（本刊编辑部）

