Other Headaches

Last updated: May 8, 2019

[Chronic Daily Headache 1](#_Toc5997540)

[Sexual Headache 1](#_Toc5997541)

[Benign Cough & Exertional Headache 2](#_Toc5997542)

[Cervicogenic Headache & Occipital Neuralgia 3](#_Toc5997543)

[Hypnic Headache 3](#_Toc5997544)

Chronic Daily Headache

Wide definition - any headaches occurring > 15 days per month and ≥ 6 months in year.

1. chronic **tension-type** headache.
2. transformed **migraine**
3. **cluster** headache
4. chronic paroxysmal hemicrania
5. hemicrania continua
6. rebound (analgesic-abuse) headache

More narrow definition - headaches on ***almost daily basis*** (> 4 days per week) + features of both **migraine** and **tension-type headache** + frequently (but not always!) associated with ***analgesic overuse***.

* + *most difficult headache patients to treat* (account for major proportion of patients seen in headache specialty clinics).
	+ typical patient - **woman** in her 30s-40s with **history** of either episodic migraine or episodic tension-type headache beginning in teens or 20s → headaches gradually increase (over months to years) in both severity and frequency → consecutive headache-free days are rare.
	+ headaches are of two types:
		1. ***mild to moderate*** frequent headaches with pressure-like (or mildly throbbing) quality and mild photophobia or phonophobia (but no nausea or vomiting!).
		2. superimposed ***severe*** attacks – usually (but not always!) throbbing ± nausea, photophobia, phonophobia, sometimes vomiting; may be preceded by migrainous aura.

N.B. chronic daily headaches are referred to as **transformed migraine** when migrainous component is prominent.

* + frequently patient is taking one or more **daily analgesics** (most often overused medications - butalbital combinations, ergotamines, oral analgesics containing caffeine and acetaminophen or NSAIDs, opiate combinations).
	+ headache is often accompanied by other distressing paroxysmal symptoms - dizziness (both vertiginous and non-specific forms), tinnitus, extreme phonophobia, fluctuating fatigue or mood alteration, and feelings of depersonalization.

Features of ***depression*** or ***anxiety*** are frequent!

* + ***neuroimaging*** is recommended only if headache has atypical features.
	+ treatment - **withdraw overused medication** + i/v DHE for 2-3 days + start prophylaxis (**β-blockers**, **anticonvulsants** [valproate, topiramate], **Ca-channel blockers**, **tricyclic antidepressants**, **SSRIs**, **ergots** [methysergide, ergonovine maleate]).

Sexual Headache

* **male**-dominated (4:1) syndrome.
* precipitated by coitus or masturbation, in ***absence of any intracranial disorder***.
* abrupt in onset and subside in few minutes if coitus is interrupted.
* often associated with benign exertional headache.
* can sometimes be prevented by ergotamine or indomethacin.
* endurance training may provide relief.

3 types recognized in IHS classification (lifetime prevalences – 1% of each type):

* 1. **Dull type** - dull ache in head (occipital or diffuse) and neck; intensifies as **sexual excitement increases** (most severe at orgasm).
	2. **Vascular / explosive** - begins at or shortly before **orgasm**; sudden, severe, explosive or throbbing frontal or occipital headache; persists for few minutes to 48 hours.

N.B. unruptured cerebral aneurysm has presented as coital headache! - for new type 2 coital headache persisting for hours (esp. with vomiting), CT / MRA should be performed (if negative → lumbar puncture)

* 1. **Postural headache** - resembles low CSF pressure headache; develops **after coitus**.

Benign Cough & Exertional Headache

- transient, severe head pain on coughing, sneezing, weight-lifting, bending, straining at stool, or stooping in ***absence of any intracranial disorder***.

N.B. coughing and exertion can aggravate any type of headache!

prevalence ≈ 1%; **men**-dominated (4:1); mean age of onset **55 yrs**.

* many patients date origin to *lower respiratory infection* accompanied by severe coughing or to *strenuous weight-lifting programs*.

Clinical Features

* pain begins **immediately** (or within seconds) after muscular effort / coughing.

vs. **effort migraine** - build up over hours.

* **severe** **bilateral** (35% unilateral), throbbing, bursting, explosive.
* bending head or lying down may be impossible.
* *autonomic symptoms* are unusual; *vomiting* suggests **organic basis** for headache!
* lasts few seconds ÷ few minutes (**cough headache**), up to 24 hours (**exertional headache**); sometimes followed by dull ache for hours.
* course duration - few years.

Diagnosis

**MRI** must be performed - to rule out **symptomatic exertional headache** (found in 25% cases):

1. ***posterior fossa abnormalities***!!! (e.g. posterior fossa meningiomas, acoustic neurinoma, midbrain cysts, basilar impression, Chiari malformations).
2. ***subarachnoid hemorrhage***.

Prophylactic therapy

**Benign cough headache** - respond dramatically to indomethacin (50-200 mg/d).

* if indomethacin fails → naproxen, ergonovine, phenelzine (not propranolol!).

**Benign exertional headache** – ergotamine, propranolol, therapeutic *lumbar puncture* with removal of 40 mL CSF.

Cervicogenic Headache & Occipital Neuralgia

- controversial entity (existence has been questioned).

* causes - developmental abnormalities, tumors, ankylosing spondylitis, rheumatoid arthritis, osteomyelitis; **occipital nerve** is vulnerable to compression as it passes through *semispinalis capitis* muscle.
* pain from cervical structures is referred to head through C1-4 cervical roots.
* prevalence unknown; risk factor - whiplash injury.

Clinical Features

* moderate severity, aching / burning, in distribution of **occipital nerve**.
* ***upper cervical region*** is often tender (palpation results in pain radiation to head).
* relief may occur after *anesthetizing* occipital nerve or C2 cervical root.

Diagnosis

* abnormal cervical **X- ray** and **MRI** are common and cannot be used by themselves to establish diagnosis.
* positive response to **neuroblockade** is not diagnostic.

Prophylactic therapy

* 1. physical therapy
	2. muscle relaxants, tricyclic antidepressants
	3. nerve blocks or trigger point injections.
		+ surgery is often useless or harmful - ***occipital neurectomy*** is usually unsuccessful and may cause anesthesia dolorosa.

Hypnic Headache

- rare primary headache syndrome of **elderly** (mean age of onset ≥ 60 years).

Clinical Features

* typically ***awakens patient from sleep*** about same time each night (similar to cluster headaches), ≥ 4 nights per week.
* headache **diffuse**, often **bilateral** and **throbbing** (vs. cluster headaches), no autonomic symptoms.
* headache can be worsened by lying down.
* headache persists for 15-60 minutes.

Diagnosis

- exclusion of organic disease – **imaging**, **ESR**.

Prophylactic therapy

- low-dose lithium (30 mg every night), caffeine, indomethacin.

Bibliography see [p. S24 >>](http://www.neurosurgeryresident.net/S.%20Symptoms%2C%20Signs%2C%20Syndromes%5CS20-29.%20Pain%2C%20Headache%2C%20Opioids%2C%20Sensory%20Disorders%5CS24.%20GENERAL%20-%20Headache.pdf)

[Viktor’s Notes℠ for the Neurosurgery Resident](http://www.neurosurgeryresident.net/)

[Please visit website at www.NeurosurgeryResident.net](http://www.neurosurgeryresident.net)