

Other Headaches

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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 \rightarrow headaches gradually increase (over months to years) in both severity and frequency \rightarrow 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 \pm 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)
3. **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):

- a) **posterior fossa abnormalities!!!** (e.g. posterior fossa meningiomas, acoustic neurinoma, midbrain cysts, basilar impression, Chiari malformations).
- b) **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 \geq 60 years).

CLINICAL FEATURES

- typically *awakens patient from sleep* about same time each night (similar to cluster headaches), \geq 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 >>

Viktor's NotesSM for the Neurosurgery Resident
Please visit website at www.NeurosurgeryResident.net