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 → 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)
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 ≥ 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.
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