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 C_{1-4} 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 C_2 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