Managing Chronic Headache Disorders

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KEYWORDS

• Headaches • Migraines • Treatment • Cluster headaches • Red flags • Primary care • Botox • Pregnancy

KEY POINTS

- Most women who are of child-bearing age and suffer from headaches have migraines. However, these headaches usually go untreated because of a lack of knowledge on how to make the correct diagnosis.
- There are many treatment options for migraines, both specific and nonspecific. These options include pharmacologic, nonpharmacologic, and interventional. Patients who are experiencing frequent attacks or those who are experiencing disability should be placed on preventative medication.
- Patients who complain of headaches should have a complete evaluation to first rule out any "red flags."
- Most pregnant women experience a reprieve from their migraines. However, if the migraines persist, there are treatment options available.

INITIAL EVALUATION OF HEADACHES

When a clinician evaluates a patient who presents with a complaint of headache, it is imperative to first distinguish between a primary headache (for example, migraine) and a secondary headache (for example, brain tumor). Primary headaches are symptom based and, to date, have no organic or structural abnormality.[1] They are misinterpreted as benign but these headaches cause significant impairment in quality of life. Secondary headaches are etiologically based and can simply be secondary to a febrile

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illness. Secondary headaches account for less than 10% of headaches in the US population. Despite this low number, one must be diligent in ruling out the secondary causes before diagnosing a primary headache disorder. One approach to help the clinician make the appropriate headache diagnosis is to follow 3 easy steps. Step one[1] requires the clinician to perform a thorough history and a detailed physical examination. A history should include at least onset of headache, prior history and family history of headaches, activity at time of headache, intensity with special attention to severity at onset, location and character of head pain, interference with quality of life, any associated nausea, vomiting, photophobia, phonophobia, osmophobia, eye tearing, nasal congestion, aura symptoms such as scintillating lights, loss of vision, paresthesias, or weakness of an extremity. Response to prior treatment including all current medications and herbal remedies should be documented. An invaluable tool is the headache diary. This diary should be user-friendly and is useful at the initial visit and subsequent visits to monitor progress with the treatment plan. The physical examination will help to confirm the initial diagnostic impression gathered from the history. The key components of a physical examination for headache should begin with documenting blood pressure, heart rate, and respiratory rate. A behavioral assessment should be conducted, observing for sedation/drowsiness, agitation, and pacing. Meningeal signs should be assessed for possible meningitis. Following the mental status examination, motor, sensory, reflexes, and gait testing should be completed. A brief musculoskeletal evaluation should be performed to examine for underlying cervical or temporomandibular joint abnormality.

Step 2 involves identification of "red flags" (**Table 1**).

Martin[2,3] has provided a useful mnemonic, SNOOP4, to assist physicians in remembering the "red flags" for secondary headache disorders. The "red flags" having the most supportive data for identifying secondary headache disorders include (a) headache of sudden onset, (b) headache associated with neurologic signs and symptoms, and (c) headache onset after the age of 50.[4]

In Step 3, the clinician should determine the necessity for ancillary testing. In general, laboratory studies are not useful in making a headache diagnosis.[5] For a baseline, routine complete blood count assessing for infection or anemia should be part of an initial headache workup. Thirty[6] percent of patients with hypothyroidism complain of headache. Therefore, thyroid function test should also be included. Other laboratory testing such as antiphospholipid antibodies should be considered only in individuals with migraine with prolonged aura (>60 minutes), elevated partial thromboplastin time, history of repeated miscarriages, and venous thrombosis. Erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) should be tested in someone with new or a change in headache over the age of 50. A lumbar puncture (LP) should be done after confirmation of an magnetic resonance imaging (MRI)/computed tomographic (CT) head scan to investigate an infectious process and to measure opening pressure to rule out idiopathic intracranial hypertension (IIH), and hemorrhage.

Neuroimaging recommendations for acute headache as per the American College of Emergency Physicians[7] are as follows: patients presenting to the emergency room with headache and new abnormal neurologic sign; new onset headache; human immunodeficiency virus (HIV) patients with new type of headache; and patients greater than 50 years of age with new type of headache despite a normal neurologic examination. As per the American Academy of Neurology,[8] neuroimaging is not warranted in patients presenting with migraine headaches and a normal neurologic examination. In general, if the clinician does not feel comfortable making the diagnosis of migraine in a patient presenting with an acute headache, a referral to a headache specialist or at least a brain imaging study should be considered.