



Diagnosis and Management of Headache in Older Adults

Amaal J. Starling, MD



From the Department of Neurology, Mayo Clinic Hospital, Phoenix, AZ.

CME Activity

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Learning Objectives: On completion of this article, you should be able to (1) differentiate between a primary vs a secondary headache disorder in older adults, (2) diagnose and guide treatment for common secondary headache disorders in older adults, and (3) evaluate the risks and benefits of medications used for the treatment of primary headache disorders in older adults.

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Dr Starling is on the advisory board for eNeura Inc; has attended advisory board meetings for Alder BioPharmaceuticals Inc, Amgen Inc, and Eli Lilly and Company; and has consulted for Amgen Inc and Eli Lilly and Company.

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Abstract

Headache is a common, disabling neurologic problem in all age groups, including older adults. In older adults, headache is most likely a primary disorder, such as tension-type headache or migraine; however, there is a higher risk of secondary causes, such as giant cell arteritis or intracranial lesions, than in younger adults. Thus, based on the headache history, clinical examination, and presence of headache red flags, a focused diagnostic evaluation is recommended, ranging from blood tests to neuroimaging, depending on the headache characteristics. Regardless of the primary or secondary headache disorder diagnosis, treatment options may be limited in older patients and may need to be tailored to the presence of comorbid medical conditions. The purpose of this review is to provide an update on the management of headache in older adults, from diagnosis to treatment.

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Although its prevalence decreases in persons after age 40 years, headache remains a substantial problem for older adults and requires careful consideration

of diagnostic and therapeutic options, especially in the setting of other risk factors and comorbid medical conditions.^{1,2} In older adults, the prevalence of headache has been reported

TABLE 1. Headache History Red Flags—SNOOP4

S	Systemic symptoms, fevers, chills, myalgias, weight loss
N	Neurologic symptoms, focal
O	Older age at onset, >50 years
O	Onset, thunderclap headache onset
P ₁	Papilledema
P ₂	Positional
P ₃	Precipitated by Valsalva maneuver or exertion
P ₄	Progressive headache or substantial pattern change

Data from *Semin Neurol*.⁶

to range from 12% to 50%,^{1,3} with frequent headache (more than 2 times per month) occurring in up to 17% of people older than age 65 years.⁴ Although headache in older adults is most likely caused by a primary headache disorder, such as tension-type headache (TTH) or migraine, older age increases the risk of a secondary cause of headache.^{1,2} For this reason, new-onset headache in older adults requires a methodical review of possible secondary headache disorders and a diagnostic evaluation ranging from blood tests to neuroimaging. In addition, older patients have more comorbid medical conditions, which not only places them at a higher risk of secondary headache but also presents challenges for treatment of primary or secondary headache disorders. Medication overuse, polypharmacy, and altered pharmacokinetics are also concerns for older patients. This review will describe the diagnosis and management of headache in older adults. For this review, *older adult* was defined as a person aged 50 years or older.

SECONDARY HEADACHE

Regardless of a patient's age, the first step in the diagnosis of a new-onset headache is to exclude a secondary headache. A secondary headache is one that is present because of another condition, such as inflammation, intracranial lesions, structural spinal abnormalities, medications, or other medical comorbid conditions. In every patient with a new-onset headache, a detailed clinical history should be obtained, noting headache red flags, and a comprehensive neurologic examination should be performed. This approach is no different in older adults, especially because

age is a risk factor for secondary headache disorders. The risk of a worrisome, potentially life-threatening secondary headache is increased 10-fold in those 65 years and older.¹ In a cohort of patients with sudden death who presented with headache, 55% were older than 50 years.⁵ Most of the sudden deaths were secondary to vascular events, including aneurysmal rupture, intracranial hemorrhage, and cervical artery dissection. In another series of patients with new-onset headache, 15% of those 65 years or older had a secondary headache compared with 1.6% of patients younger than 65 years.¹ SNOOP4 is a previously published mnemonic for secondary causes of headache.⁶ SNOOP4 is applicable for patients of all ages, including those who are older (Table 1),⁶ and stands for systemic symptoms; neurologic symptoms; older age at onset of headache; onset of headache attack (eg, a thunderclap headache onset); and papilledema, postural, precipitated by Valsalva maneuver, and progressive headache or substantial pattern change. Depending on the specific red flags, diagnostic testing in older patients will vary but should include blood tests, including erythrocyte sedimentation rate (ESR), and neurovascular imaging to look for a vascular or space-occupying lesion. Table 2 presents secondary headache disorders that are more common in older patients and diagnostic red flags that can be gleaned from the clinical history and examination.

Cerebrovascular Ischemic Event

Age and other vascular risk factors increase the risk of a cerebrovascular ischemic event, and vascular risk factors are more common in older adults. Strokes and transient ischemic attacks (TIAs) result in focal neurologic deficits, such as face, arm, or leg weakness; sensory loss; ataxia; or difficulty with speech or vision. Posterior circulation strokes are more likely to cause headache than anterior circulation strokes.⁷ It is important to note that older adults are more likely to have migraine aura without headache,^{8,9} which can mimic a TIA; the onset and progression of transient neurologic symptoms are clues to the correct diagnosis. When sudden onset of unilateral arm sensory loss occurs, an ischemic event should be considered, whereas a march or progression of unilateral arm paresthesias,

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