

Headache

Barry Snow

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- what is/are the diagnoses?
- how would you manage her?

Migraine

- 94% pts seen in primary care settings for HA have migraines
- Familial
- 17 – 18.2% of adult females. Onset puberty
- 6 – 6.5% adult males. Onset 20-30
- Peaks ages 22-55.
- ½ migraine sufferers not diagnosed.

Common misdiagnoses for migraine:

- Sinus HA
 - Stress HA
 - Cervical headache
-
- Referral to ENT for sinus disease and facial pain.
 - New glasses
 - Pulled teeth
 - Endless chiropractic treatment

Migraine is a hypersensitivity disorder

- Migraineurs more likely to have motion sickness.
 - Half of Meniere's patients have migrainous symptoms.
- Nausea
- Photophobia
- Osmophobia
- Phonophobia
- Allodynia

Migraine is a genetic disorder

- ~70% positive family history
- Rs1835740 marker on 8q22.1
- Located between two genes involved in glutamate homeostasis

Modifying and Precipitating factors

- stress
- head and neck infection
- head trauma/surgery
 - post traumatic migraine
- caffeine withdrawal
- aged cheese
- dairy
- red wine
- nuts
- shellfish
- vasodilators
- perfumes/strong odors
- irregular diet/sleep
- light

Migraine

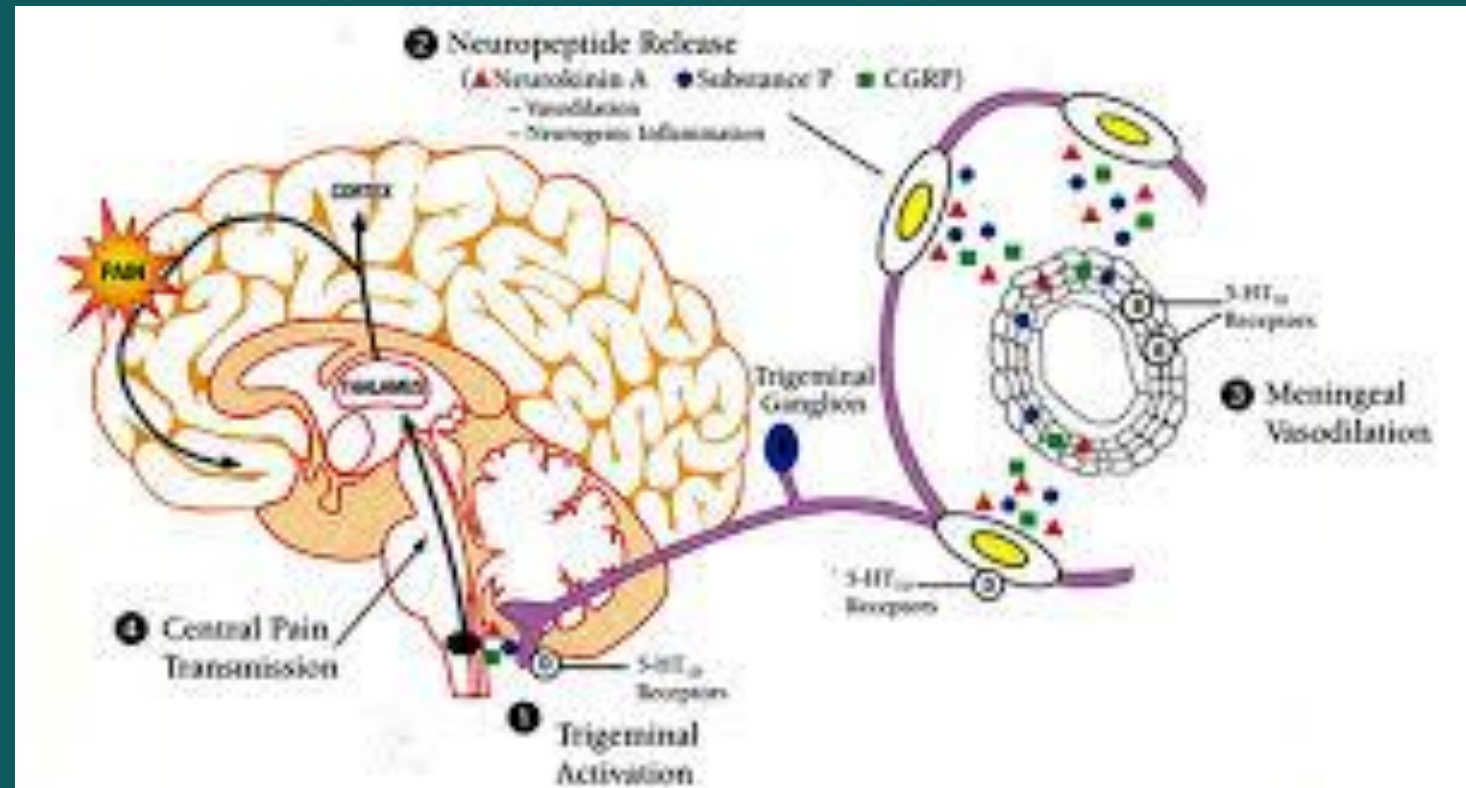
- A genetically-based hypersensitivity disorder that is modified by environmental factors

Migraine

- A genetically-based hypersensitivity disorder that is modified by environmental factors
 - Excuses the patient from blame
 - Explains associated symptoms
 - Justifies the addressing of associated factors, but indicates why this is only partially successful

Migraine mechanism

- Primary brain disorder
- Modulated by serotonin
- Secondary vascular mechanisms



What happens?

- 549 Danish patients over 12 years
- Migraine
 - 42% remission
 - 38% low frequency
 - 20% poor outcome
 - (predictors: high frequency, age <20)
- TT headache
 - 45% remission
 - 39% frequent
 - 16% poor outcome
 - (predictors: co-existing migraine, unmarried, poor sleep)

Progression of migraine

- 6% move from low-frequency into high-frequency episodic migraine/year
- 3% episodic to chronic migraine / year

Chronic daily headache

- 3-4% of adults
- Chronic tension-type headache
- Transformed migraine
 - Drug-induced headache
- Often cutaneous allodynia
- Transformation rate ~2.5%/year

Risk of Transformation

- lower levels of education and household income.
- older
- higher body mass indexes
- snoring
- anxiety
 - (depression accounted for by disability)
- stressful life events
- high baseline attack frequency
- overuse of certain classes of medication
- caffeine overuse
- head injury
- allodynia

Medication overuse headache

- >8 days/month opiates
- >10 days/month tryptans
- NSAIDS protect at frequency of <10 days/month, but exacerbate in high frequency >15 days
- Worse on analgesic withdrawal

Vascular disease and Migraine

- Migraine increases risk of stroke by 1.73 (2.08 in women)
- Aura 2.2, no aura 1.2
- Increased risk of myocardial infarction and other vascular disease (approx 2)

Migraine treatment

- Control pain
- Control other symptoms
- Prevent attacks
- Prevent progression to CM
- Prevent co-morbidities

Treatment

- determine the frequency and duration of attacks
- determine associated symptoms
- consider triggers, especially stress
- think about the time-linked headaches

Treatment

- Non-pharmacologic management
 - exercise
 - normalize sleep
 - address stress
 - (?biofeedback, relaxation techniques)

Treatment

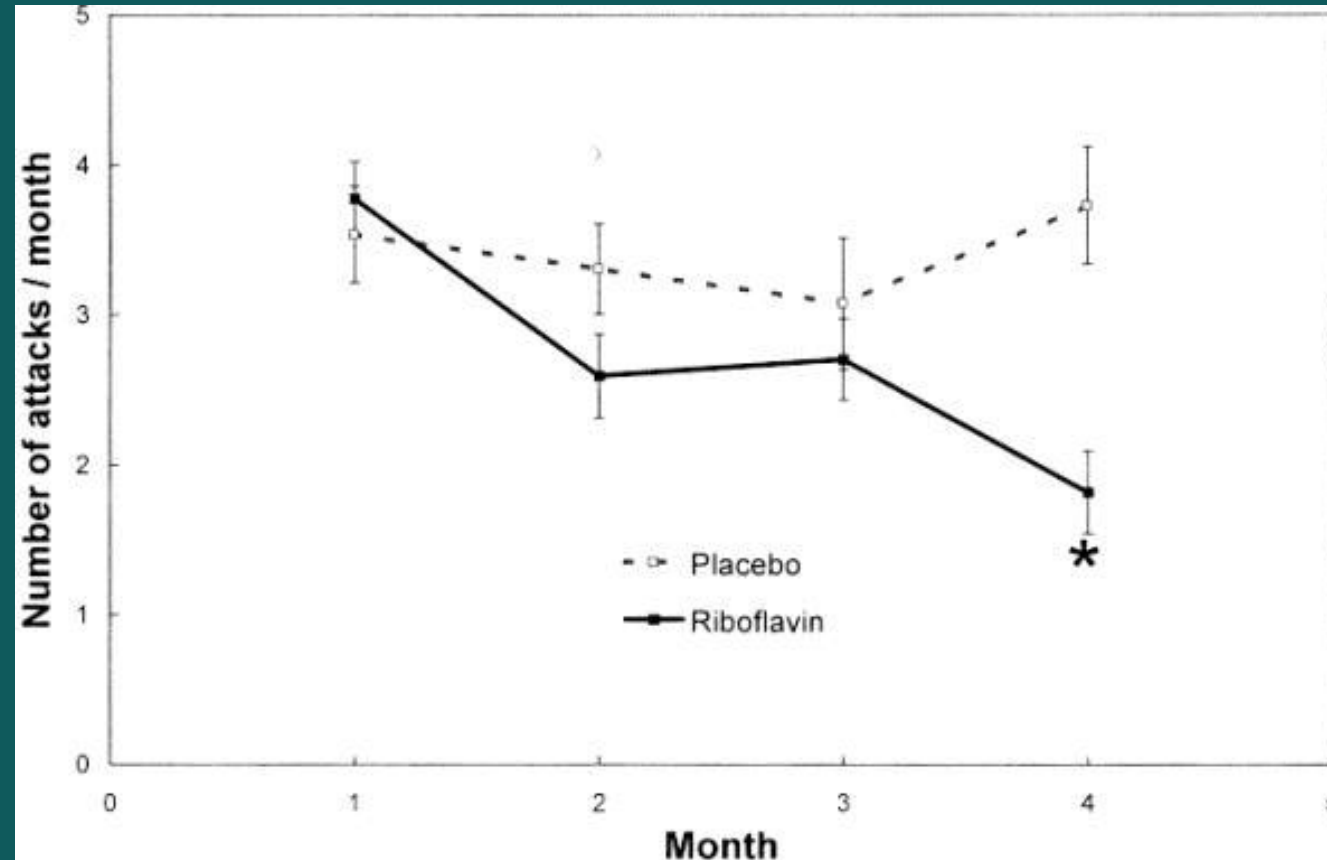
- Abortive therapy - high dose and early
 - paracetamol
 - NSAIDs
 - sumatriptan, rizatriptan, zolmitriptan
 - metoclopramide, prochlorperazine

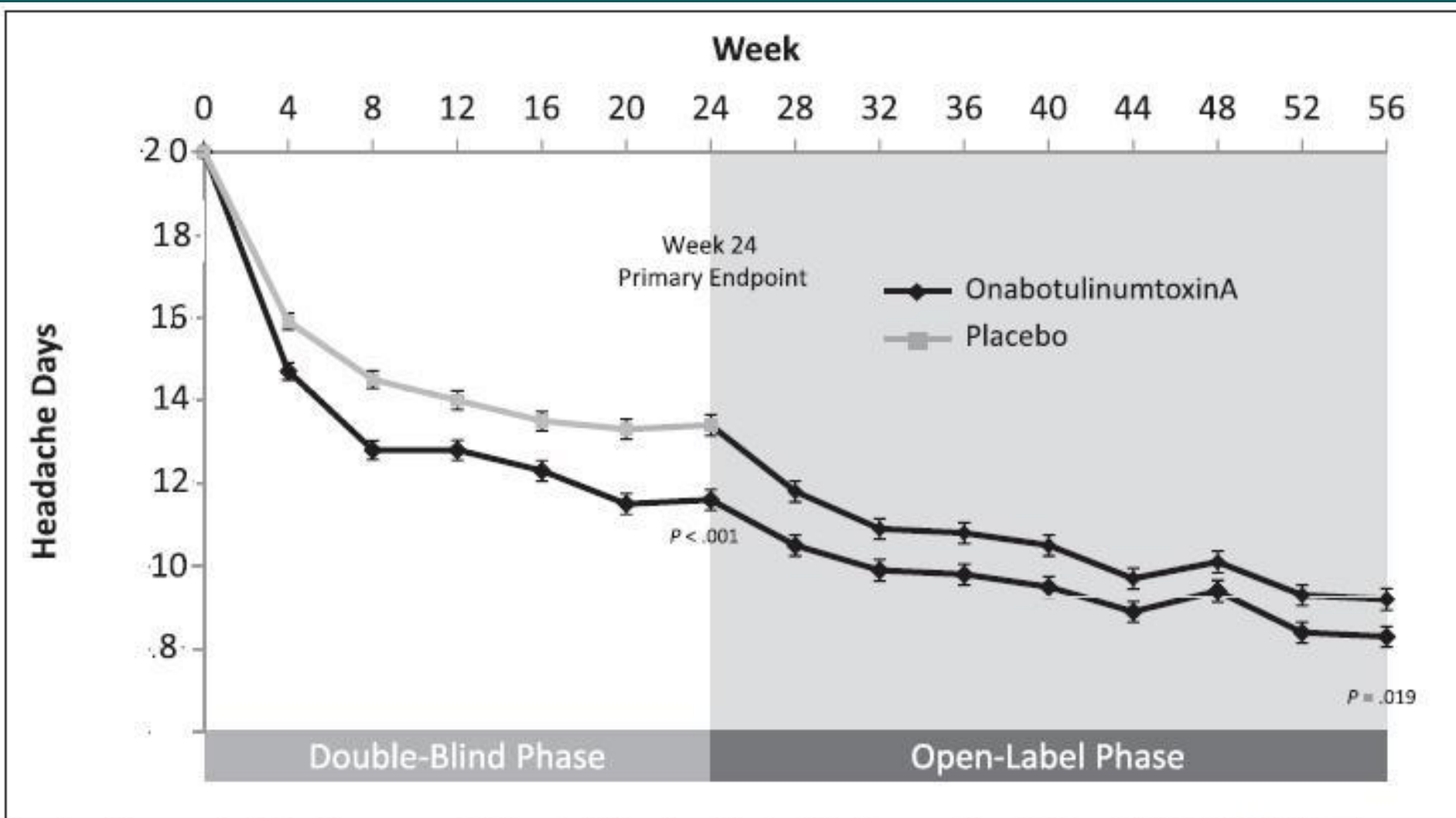
Treatment

- Prophylaxis - high dose and for a month at least
 - riboflavin
 - tricyclic antidepressants
 - beta-blockers
 - topiramate
 - calcium antagonists
 - valproate
 - gabapentin
 - (MAO inhibitors, other anticonvulsants, methysergide)
 - Botulinum toxin

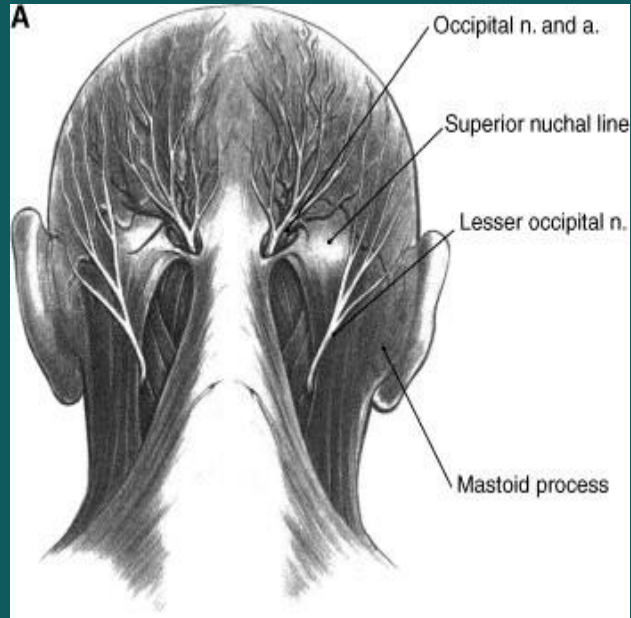
Riboflavin

- 55 patients. RCT





OnabotulinumtoxinA for Treatment of Chronic Migraine: Pooled Analyses of the 56-Week PREEMPT Clinical Program. Sheena K. Aurora et al Headache 2011;51:1358-1373



Brief intervention for medication-overuse headache in primary care. The BIMOH study: a double-blind pragmatic cluster randomised parallel controlled trial

Espen Saxhaug Kristoffersen,^{1,2} Jørund Straand,¹ Kjersti Grøtta Vetvik,^{3,4,5}
Jūratė Šaltytė Benth,^{2,4} Michael Bjørn Russell,^{3,4} Christofer Lundqvist^{2,4,5}

J Neurol Neurosurg Psychiatry 2015;**86**:505–512.

- Do you think your use of headache medication is out of control?
- Does the prospect of missing a dose make you anxious?
- Do you worry about your use of your headache medication?
- Do you wish you could stop?
- How difficult would you find it to stop or go without your headache medication?

