

HOSPITAL PHYSICIAN®

NEUROLOGY BOARD REVIEW MANUAL

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The *Hospital Physician Neurology Board Review Manual* is a peer-reviewed study guide for residents and practicing physicians preparing for board examinations in neurology. Each manual reviews a topic essential to the current practice of neurology.

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Clinical Approach to the Patient with Headache

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Clinical Approach to the Patient with Headache

Catherine Lavigne, MD, and Paul B. Rizzoli, MD, FAAN

INTRODUCTION

Headache is a common and potentially disabling disorder. Under certain circumstances of pattern, frequency, severity, and other factors, the disorder may qualify for a diagnosis of a *primary headache*. Under other circumstances, headache may reflect an underlying illness or condition (ie, a *secondary headache*). Differentiating between primary and secondary headache is the first and most critical step in the diagnostic process. This manual reviews the clinical features of selected primary headache disorders and describes key points to diagnosis and management using illustrative case studies.

HEADACHE CLASSIFICATION

Currently, the most widely used system for classifying headache is that of International Headache Society, the International Classification of Headache Disorders, Second Edition (ICHD-2; available at <http://ihs-classification.org/en>).¹ The ICHD-2 is designed primarily to afford diagnostic consistency for research purposes, but it is helpful in establishing the correct diagnosis which then guides treatment.

Part 1 of the ICHD-2 classifies primary headache (ie, those with no other known cause) as 1 of 4 main types: migraine, tension-type headache, cluster headache and other trigeminal autonomic cephalalgias (TACs), and other primary headaches (**Table 1**). Migraine is further subclassified as migraine with or without aura (which can include either the traditional visual aura, sensory symptoms, or dysphasic symptoms), retinal migraine, complications of migraine, or probable migraine. Tension-type headache is further subclassified as infrequent, frequent, chronic, or probable. Cluster headaches are grouped with the relatively rare conditions of paroxysmal hemicrania, short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT syndrome), and probable TAC. Finally, other primary headaches include both common and uncommon conditions: stabbing, cough, exertional, hypnic, and thunderclap headaches; head-

ache associated with sexual activity; hemicrania continua; and new daily-persistent headache. Secondary headaches comprise Part 2 of the ICHD-2 (Table 1).

From a clinical standpoint, the ICHD-2 classification system is missing several commonly seen headaches. For example, chronic daily headache and menstrual migraine do not appear in the system, although these diagnoses remain in wide clinical use. Menstrual migraine does not easily fit into the classification system because it includes a trigger in the individual patient and thus is not descriptive of the headache itself. It has since been added to the appendix of the 2004 classification. Chronic migraine and chronic tension-type headache appear in the system, along with a category for new daily-persistent headache, but not chronic daily headache.²

PREVALENCE

Among the primary headache disorders, migraine and tension-type headache are encountered most often, and cluster headache is under-recognized. Migraine affects about a quarter of the U.S. population during their most productive years, producing a significant burden on affected patients, the health care system, and society as a whole. Overall migraine prevalence is highest among those aged 25 to 55 years. Peak prevalence of migraine in the United States is about 18% in women and 6% in men,³ for a total of approximately 28 million Americans.

When mild and infrequent, tension-type headache is generally not considered a health issue. When frequent (1–15 headaches/month) or chronic (> 15 headaches/month), tension-type headache constitutes a major health problem. Prevalence of episodic tension-type headache is approximately 38% of the population, whereas chronic tension-type headache is 2% to 3%.⁴

Although a relatively rare form of primary headache, cluster headache is as common as or more common than multiple sclerosis, an illness that neurologists see quite often. Unfortunately, cluster headache is a severely painful and disabling headache that is often misdiagnosed. In 3 recent studies evaluating cluster headache, the prevalence ranged from 69 to 326 per 100,000 population.^{5–7}