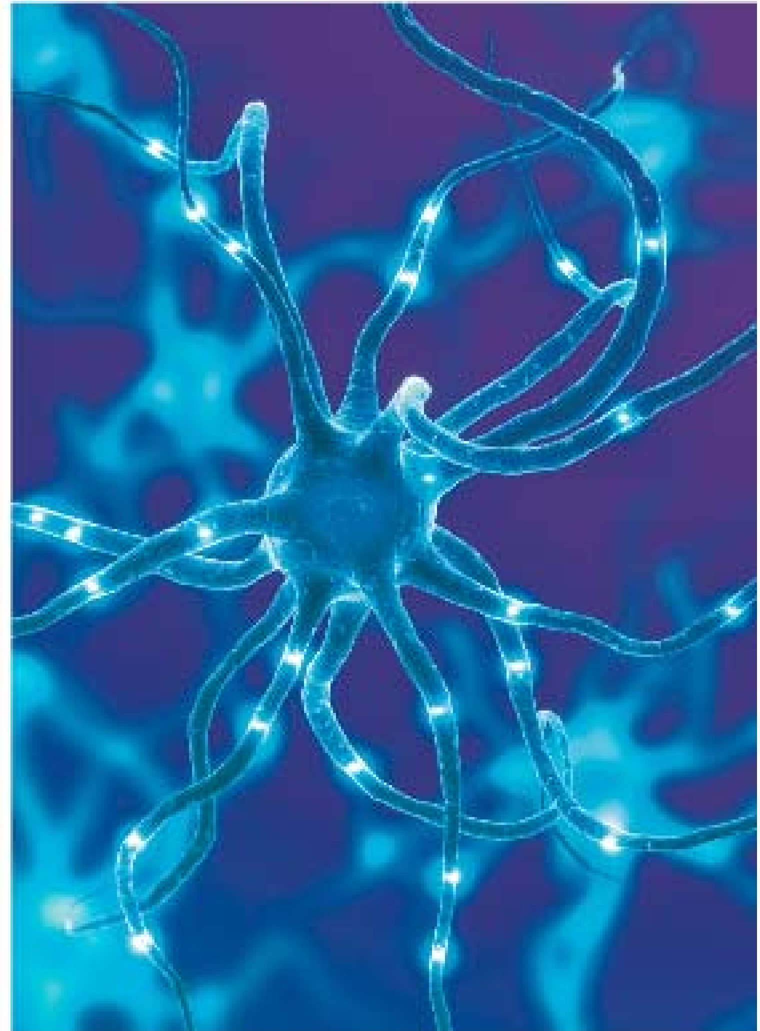
American Headache Society

Headache Curriculum

Eric M. Pearlman, MD, PhD
Assistant Professor of Pediatrics
Mercer University School of Medicine
Savannah, GA



Woman with Frequent Headaches

Learning Objectives

- At the conclusion of this case, participants should be able to:
  - Recognize chronic migraine and distinguish it from other headache disorders and
  - Be familiar with evidence-based treatment choices for management of patients with frequent headache and/or migraine.

Medical History

- JW is a 47-year-old woman
- Headache occurring virtually daily
- History of migraine without aura since age 16 y
  - Moderate-to-severe intensity
  - Associated with photophobia, phonophobia, and nausea
- Disability: movement made pain worse or exacerbates the throbbing
- Used NSAIDs and ASA for years; @ 37 yo started triptan

Complaints at Clinical Presentation

- 6 months ago, she noticed an increase in migraine frequency
  - 3/wk (about 18 headache days per month)
  - Less severe in intensity
  - Associated with photophobia and nausea
  - Symptoms often worsen with movement or activity
- Difficulty falling asleep and staying asleep
  - Feelings of sleep deprivation

Medication History

Medical history

- Migraine headache- since teen years. Previously tried topiramate and propranolol as preventive therapies without success
- Generalized anxiety
- History of depression
- Peptic ulcer disease
- Hypercholesterolemia

Current Medications

- Triptan PRN
- Combination analgesic (AAC) for rescue PRN (< 5/mo)
- Citalopram 40 mg po qd for headache prevention, anxiety and potential depression
- Pantoprazole 40 mg po qd for peptic ulcer disease
- Simvastatin 20 mg po qd for hypercholesterolemia

Family/Social History

Family history

- Father: hypertension, hypercholesterolemia
- Mother: noninsulin-dependent diabetes
- Sister: episodic migraine without aura

Social history

- Married, 3 children (2 home, 1 college).
- Accountant at large firm

AMERICAN HEADACHE SOCIETY
www.AmericanHeadacheSociety.org

American Headache Society
Headache Curriculum

Review of Systems

- Complains of fatigue but denies any recent infections or illness
- Weight and appetite have been stable
- No recent or remote history of head trauma
- No SOB, dyspnea, dizziness, or syncope
- No chest pain
- No abdominal pain, vomiting, diarrhea, or constipation
- Denies BRBPR or melena
- Denies hematuria
- Menstrual periods are regular
- Denies arthralgias or myalgias
- Denies focal motor weakness or loss of sensation
- Mood: “ frustrated about the headaches”; can’t sleep
- Sexually active but frequent headaches impacted sex drive

Question 1

Which of the following would be useful in the further evaluation of this patient?

- ❑ Additional history about medication use
- ❑ MRI
- ❑ CT
- ❑ CBC and laboratory tests
- ❑ Additional history regarding sleep, depression and anxiety

Question 1

Which of the following would be useful in the further evaluation of this patient?

- ✓ Additional history about medication use
- ❑ MRI
- ❑ CT
- ✓ CBC and laboratory tests
- ✓ Additional history regarding sleep, depression and anxiety

When might MRI and CT be warranted? “SNOOP”

- **S**YSTEMIC SYMPTOMS (fever, weight loss) or SECONDARY RISK FACTORS (HIV, systemic cancer)
- **N**EUROLOGIC SYMPTOMS or abnormal signs (confusion, impaired alertness or consciousness)
- **O**NSET: sudden, abrupt, or split-second
- **O**LDER: new onset and progressive headache, especially in middle age >50 yr (giant cell arteritis)
- **P**EVIOUS HEADACHE HISTORY: first headache or different (change in attack frequency, severity, or clinical features)

Additional Medication History

- Age 30: 4-week course of propranolol 40 mg
  - Followed by 4 week course of 80 mg
  - Discontinued
- Age 43: 1 week topiramate 50 mg/d
  - Escalated to 100 mg/d
  - Discontinued after 2nd week due to paresthesias
- Current medications
  - Citalopram 3 months, no change in HA frequency
  - AAC/NSAIDs 3-5 times per month
- No alcohol or tobacco use; morning caffeine use
  - No exacerbation of HA when not drinking caffeine

Additional Psychosocial History

Additional history regarding sleep and depression

- Difficulty 'winding down' at night to go to sleep
  - 30 minutes to 3 hours to fall asleep
  - Awakens around 3:00 am and unable to go back to sleep
  - No snoring or other symptoms of obstructive sleep apnea
  - No symptoms of restless leg syndrome
  - No symptoms of daytime somnolence or narcolepsy
- If she had symptoms characteristic of a primary sleep disorder, a polysomnogram and/or multiple sleep latency test may be appropriate

Question 2:
What is the primary diagnosis for this patient?

- ❑ Episodic migraine
- ❑ Chronic migraine
- ❑ Chronic tension-type headache
- ❑ Medication overuse headache
- ❑ Caffeine withdrawal headache

Question 2:
What is the Primary Diagnosis for JW?

- ❑ Episodic migraine
- ✓ Chronic migraine
- ❑ Chronic tension-type headache
- ❑ Medication overuse headache
- ❑ Caffeine withdrawal headache

Clinical Course I

- Provided a diagnosis of chronic migraine without aura
- Instructed to identify migraine attacks vs other HA types
- Advised on life-style modifications:
  - Regular exercise
  - Routine meals
  - Regular sleep hygiene
  - Stress management
- Counseled to monitor/restrict daily use of caffeine and other analgesic/rescue medications
  - Reviewed risk of developing medication-overuse headache
  - Restrict to < 2 doses per week
  - Switch to NSAID with no caffeine (eg. naproxen sodium)

Question 3: What migraine preventive medication might be appropriate in this patient?

- ❑ Paroxetine
- ❑ Verapamil
- ❑ Atenolol
- ❑ Amitriptyline

American Headache Society Headache Curriculum

Question 3: What migraine preventive medication might be appropriate in this patient?

- ❑ Paroxetine
- ❑ Verapamil
- ❑ Atenolol
- ✓ Amitriptyline

For migraine, effective doses of amitriptyline range from 30-100 mg given once at night. To minimize side effects, the patient is started on 10 mg and the dose increased in 10-mg increments every 3-4 days until reaching the target dose (eg. 50 mg). Common side effects include somnolence, weight gain, and orthostatic hypotension.

Question 4: If JW headaches gets worse in the first 3 weeks, what should be done?

- ❑ Tell her to increase her use of analgesics and triptans
- ❑ Obtain an MRI of the brain
- ❑ Change preventive medications
- ❑ Focus on good headache hygiene habits and provide reassurance
- ❑ Do additional “SNOOP” and repeat exam

Question 4: If JW headaches gets worse, what should be done?

- ❑ Tell her to increase her use of analgesics and triptans
- ❑ Obtain an MRI of the brain
- ❑ Change preventive medications
- ✓ Focus on good headache hygiene habits, provide reassurance, and manage expectations
- ✓ Do additional “SNOOP” and repeat exam