natural peak flow reading to be—especially when their child was coughing.

Comment

In this study most parents valued their peak flow meter for its usefulness in the recognition of severe asthma attacks. That 42 of the 50 parents recalled their child’s danger peak flow level to within 10% of the correct value suggests that most parents were capable of using the peak flow meter to recognize severe attacks.

Only 20% of families wrote about the usefulness of their peak flow meter for the detection of impaired respiratory function when their child was apparently well. Although we mention this potential use to parents, we prefer to teach them to assess asthma control by determining how much the asthma interferes with their child’s daily life. We are not convinced that daily peak flow measurements in apparently well children are worth the effort entailed. On the other hand, we shall continue to teach parents how to use home peak flow monitoring to recognize severe attacks of asthma. It is surprising that this use of home peak flow monitoring was not emphasised in the recently published international consensus on the management of childhood asthma.1 This was the use of home peak flow monitoring that was most valued by parents in our study and one that our study has shown can easily be taught to most parents.

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Natural course of benign coital headache

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Headache related to sexual activity has been recognised since the time of Hippocrates, but the occurrence of a distinct form of headache associated with sexual intercourse was first formally reported by Kritz in 1970.1 The condition has been given a number of names, including orgasmic cephalalgia, as it occurs usually at or near orgasm, and benign coital headache, owing to the lack of serious underlying disease.2 3 But not only is the condition unpleasant: it also has an unpredictable clinical course. The headaches may begin suddenly, continue for a time, then end abruptly; or headache may occur fairly regularly with sexual activity.4

Follow up periods in hitherto published series have not been long enough to determine the long range natural course of coital headache. We therefore report the results of an investigation of the clinical course in 26 patients followed up for up to 14 years.

Patients, methods, and results

During 1978-91, 32 patients (24 men, eight women) were seen in a private neurological clinic complaining of headache associated with orgasm. In January 1992 they were invited by letter to attend for follow up and interview focusing on the clinical course of their headache—that is, whether it was still occurring during sexual intercourse and what other kinds of headache distress there were. One patient had died of an unrelated cause.

Twenty six patients (19 men, seven women) received the invitation. The period of follow up ranged from six months to 14 years (median 6 years). Coital headache was divided into the three basic types described by Lance5 and Paulson and Klawans.6 Migraine and tension type headache were defined according to criteria of the International Headache Society.7

In all patients the headaches were very intense for five to 15 minutes, and in four patients the symptoms then disappeared and did not recur. In 22 patients the headache declined over one to 24 hours and recurred at subsequent attempts at sexual intercourse, performed within a period of up to six weeks. In four patients this period lasted three to six months. Thirteen patients experienced only one headache or one cluster of coital headaches whereas in nine men and four women the coital headache pattern reappeared after a headache free period for up to 10 years. Six of these patients had more than three recurrent clusters.

Twelve patients had recurrent attacks of headache besides their coital headaches. Five patients (four men, one woman) suffered migraine without aura whereas seven patients (five men, two women) often had tension headache. There was a significant association between the presence of concomitant headache and the occurrence of more than one cluster of coital headaches (table).

Table

<table>
<thead>
<tr>
<th>Coital headache</th>
<th>One cluster</th>
<th>Recurrent clusters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraine (n=5) or tension headache (n=7)</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>No migraine or tension headache (n=14)</td>
<td>12</td>
<td>2</td>
</tr>
</tbody>
</table>

p<0.001; Fisher’s exact test.

Comment

A characteristic of benign coital headache is the vulnerability of patients to the headache on one occasion and not on another. Some patients have only one episode; others have several episodes which do not occur with a well defined periodicity or regularity. In the present study half the patients had experienced more than one period after an interval of up to 10 years. This underlines the need for long follow up.

We found a highly significant association between the risk of having more than one cluster of disabling coital headaches and the presence of a concomitant tension headache or migraine. Thus if a patient with migraine or tension headache once has an episode of benign coital headache he or she is at great risk of having recurrent attacks. Other patients, not ordinarily suffering from headache, who seek medical advice after a typical episode of coital headache can be reassured about the favourable prognosis of this disorder.


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