10-minute consultation

Headache

Sharon K Bal, Gary R Hollingworth

This is part of a series of occasional articles on common problems in primary care

Department of Family Medicine, Faculty of Medicine, University of Ottawa, Ontario K1N 5C8, Canada
Sharon K Bal *senior resident*
Gary R Hollingworth *associate professor*
Correspondence to: S K Bal sharon_k_bal@yahoo.ca

The series is edited by general practitioners Ann McPherson and Deborah Waller (ann.mcpherson@dphpc.ox.ac.uk)

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A 32 year old woman comes to you complaining of recurrent frontal headaches. They started about a month earlier and have been steadily increasing in frequency and intensity over the past few days. She mentions stress at work and poor sleep.

What issues you should cover

Assessment—Is it a primary headache (tension, migraine, or cluster) or secondary to an underlying cause?
History—This is the crucial step in diagnosis. Many specialists advocate the use of a symptom diary, which patients can use at home to establish a temporal pattern for their headache. A separate history is required for each type of headache. Attention should be paid to the course and duration of each. Ascertain the quality of the headaches (steady, pounding, stabbing) and the intensity, perhaps by using a visual analogue pain scale. Ask about associated features such as ipsilateral rhinorrhoea (cluster headaches) or preceding aura (migraines). Also ask about precipitating and alleviating factors. Are there any predictable triggers? A family history may be relevant, as may caffeine intake and use of drugs or complementary medicines. Explore psychosocial factors such as new stressors, support, and her own fears and expectations.
Examination—Begin with a general inspection: does she look unwell? Standard checks, including blood pressure measurement, are important. Focused neurological examination, including fundoscopy, will be needed if diagnosis is uncertain or if you suspect an intracranial pathology. Examine her head and neck thoroughly for signs of meningitis, scalp tenderness, limited range of motion, or muscle tension, as indicated by the history.

Serious causes of secondary headache

- Intracranial lesion
- Meningitis
- Subarachnoid haemorrhage
- Temporal arteritis
- Primary angle closure glaucoma

Red flags signs (indicators of possible serious underlying pathology)

- Increased intracranial pressure (indicates intracranial lesion or idiopathic (benign) intracranial hypertension, a non-serious condition that can present with similar signs and symptoms to intracranial lesion)
- Night-time awakening (intracranial lesion)
- Neurological signs (intracranial lesion, meningitis)
- Constitutional symptoms such as fever, weight loss (meningitis, intracranial lesion)
- Intensity—"worst headache of my life" (subarachnoid haemorrhage)
- Previous head injury
- New onset headache in people aged over 50 years old (temporal arteritis, intracranial lesion)

Useful reading

Steiner TJ, Fontebasso M, Del Brutto OH. Clinical review: headache. *BMJ* 2002;325:881-6

British Association for the Study of Headache (BASH). Guidelines for all doctors in the diagnosis and management of migraine and tension-type headache. www.bash.org.uk/bash/guidelines.htm

What you should do

Tension headache

- Reassure her that episodic tension headache is self limiting.
- Address contributory factors such as stress or musculoskeletal abnormality (temporomandibular joint disorders, dental malocclusion).
- Depression and drug overuse will affect treatment success (analgesics and other drugs used to treat headache can result in medication overuse headache).
- Regular exercise and lifestyle change, including meditation, relaxation therapy, and cognitive training, may help her if stress is a major component.
- Drug treatment is less helpful but might include over the counter drugs or, infrequently, non-steroidal anti-inflammatory drugs. Avoid powerful analgesics such as opioids.

Migraine

- Precipitating factors include menstruation, stress, lack of sleep, strenuous exercise, and certain foods. Using symptom diaries to identify triggers may help in modifying these risk factors.
- Use a treatment ladder for pharmacological management, going up a step after a particular drug has failed on three occasions. Begin with simple oral analgesia: paracetamol 1000 mg or ibuprofen 400 mg, preferably in soluble form, as the first step. See the BASH guidelines (see Useful Reading) for details.
- Indications for prophylaxis include a high number of attacks despite acute treatment or suboptimal relief with acute management. This is generally judged by the patient. Effective prophylactic drugs should be continued for 4-6 months then withdrawn to establish continuing need.

Cluster headache

- Timely diagnosis is essential for this very painful condition. Luckily the symptoms are characteristic.
- Acute treatment includes oxygen (100% at 7 l/min for 10-15 minutes at onset of attack), ergotamine or triptan nasal sprays, and intranasal lidocaine.
- First line prophylaxis is verapamil, preferably short-acting (120-160 mg three or four times a day).
- Referral to a neurologist is standard: analgesics have no role in management.