Step-by-step management of difficult headache cases

Difficult or dangerous or both?

primary headache?

Secondary (symptomatic) headache?

Leading Symptom Headache

dangerous or not?

2 binary headaches….

Thunderclap headache

headache, older > 60 years, impaired vision

Neuroimaging: 4 Specialists...

Thunderclap headache

Position-dependent headache

Headaches made worse by exercise

Trigemino-autonomic headaches
Mrs. SB, 24 years old, has now and then migraine attacks usually in the early morning hours, for the most part with nausea and vomiting. ASA, Paracetamol and Ibuprofen don’t work. The mother came as well, just in case.

Abortive medication

- Abortive medication: always sufficient dosage and as early as possible
- Normal attacks: painkillers and severe attacks: triptans (or even combination)
- Abortive medication never > 10 days/month

There is an exception

Medical therapy

Basic principle for abortive medication:

- High enough dosage, as soon as possible!
- (and not too often...)

Basic principle for preventative medication:

- Start low, go slow!
- (and daily...)

Dangerous? Diagnoses?

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43 year old lady with since 3 days frontal severe headaches. Photophobia, phonophobia, nausea, yesterday vomiting. Migraine runs in the family. Painkillers (NSAID) are not efficient any more. Neurological examination is normal.

Mr. SK, 44 years old, truck driver, since 1.5 h extreme and probably half-sided headache, cannot speak. Convulses on the therapy table and then paces through the room. His wife is drenched in tears. She says he is having these attacks since 3 days.

The anaesthesiologist wants to intubate.
Patient SK, 44

Neurological examination:
- Pathologic:
  - No examination possible

Dangerous (yes/no)?
Differential-diagnosis?
Procedure?

Therapy?
- Verapamil
- ECG
- Prednisone for 2 weeks

Escalation step 1:
- Verapamil
- ECG
- Prednisone for 2 weeks

Escalation step 2:
- Additive Lithium or Topiramate; eventually Verapamil

Escalation step 3:
- Tip: Frovatriptan at bedtime?

Escalation step 4:
- Admission? DHE-regime, stimulation?

Mr SK, 44 years old, truck driver, Cluster headache

Therapy?
- Oxygen, Triptan s.c.; Verapamil 3x80mg

Escalation step 1
- Verapamil
- ECG
- Prednisone for 2 weeks

Escalation step 2
- Additive Lithium or Topiramate; eventually Verapamil

Escalation step 3
- Tip: Frovatriptan at bedtime?

Escalation step 4
- Admission? DHE-regime, stimulation?

Cluster headache therapy

Abortive
- Locally:
  - Oxygen
  - Lidocain nasal

- Triptan:
  - s.c.
  - nasal

Preventative
- Verapamil (760mg)
- Lithium (450mg)
- Corticosteroids (100mg)
- Methysergide (12mg)
- Topiramate (150mg)

Cluster Headache

not validated or experimental therapy

- Capsaicine
- Xylocaine
- Lamotrigen
- Somatostatin
- DHE 3mg/day for 3 days
- invasive therapy

Mrs. HL, 44 years old, housewife, migraine known since years. Since around 1.5 years a now diffuse constant headache, Nearly not treatable. On top some well-known migraine attacks. Betablockers, Flunarizin, Topiramat, all without efficacy.

The patient declares, you are the only one left in the world who can help her now.
Medication overuse headache

- Migraine in medical history
- Holocranial continuous pain
- Dull, constant
- In part with nausea (migraine attacks)

Therapy: withdrawal

On a Friday morning you meet an older lady in front of the elevator, who can hardly speak properly because of an established trigeminal neuralgia.

To guarantee that you have fun with your headaches wherever you go

64 year old lady who cannot talk any more
The daughter tells you she has terrible pain in the left face.
No autonom or vegetative symptoms
Medical history: gallbladder stones, depression
NSAID without effect
Neurological examination unremarkable

Therapy? Carbamazepin/Oxcarbamazepin
Escalation step 1 add-on or stand alone: Gabapentin
Escalation step 2 Baclofen, Lamotrigine
Escalation step 3 Admission, Phenytoine iv.
Escalation step 4 Coagulation of the trig. ganglion; Janetta Op

Mrs. MM, 74 years old, with an extreme headache, which occurred 1 week ago and persists since then.
The headache is now dull and constant, once in the beginning nausea and vomiting

Patient MM, ♀ 74

Neurological examination:
- Somnolent, not fully oriented
- Meningism
- Babinski positive on the right side

Dangerous (yes/no)?
Differential diagnosis?
Procedure?

Diagnosis: praepontine SAB

The dangerous Headache

“Red flags” in this case:
1. New headache
2. Severe headache
3. Age > 50 a
4. Neurological findings and reduction of vigilance
5. Refractory to therapy
6. ...
Thunderclap headache
segmental vasoconstriction
potentially epileptic seizures
potentially stroke
potentially brain edema
restitutio ad integrum after 3 months

Direct DD: SAB
but local vasoconstriction
and not in the convexity
cerebral Angitis
but headache not Thunderclap-like
eventually older bleedings

Therapy:
cafe straining, valsalva
Nimodipine 7
RR-Control
Cortisone not helpful

Relevant Points:
- first-time or familiar headache
- Onset: acute or slow, when
- Localisation: uni-/bilateral, punctum maximum, Spread
- Headache Character
- Temporal Dynamics: attack-like vs. chronic, frequency, circadian or circannual rhythm
- Magnitude (0-10 on the VRS)

A good doctor
can be recognized by in the way
he treats a headache patient”