Editorial

What's in a name? The classification of common headaches

Headache is an almost ubiquitous human experience. In addition, it is a major contemporary health problem about which most clinicians are poorly informed. Over two-thirds of the population report a history of headache, with 28% fulfilling criteria for a diagnosis of migraine and 38% for tension-type headache. Patients come to medical attention either because of diagnostic doubt (is it a brain tumour?) or because of the negative impact on their quality of life. Addressing the former without the latter leaves only half the job done.

Migraine may occur with or without an aura such as scotoma, fortification spectra or paraesthesiae. Migraine headaches usually last 4-72 hours, they are often unilateral, pulsating, moderate or severe intensity and aggravated by routine physical activity. There is frequently concomitant nausea, vomiting, photophobia or phonophobia. Acute treatment with minor analgesics and anti-emetics, ergot alkaloids or sumatriptan is often successful. Prophylaxis is appropriate for patients suffering more than two attacks per month. First line prophylactic agents are beta-blockers, pizotifen and low dose amitriptyline.

Tension-type headache lasts minutes to days. The pain is bilateral in location, pressing or tightening in quality and of mild or moderate intensity. Nausea is absent, but photophobia or phonophobia may be present. It is a misnomer; though it can be associated with stress, so may other headache types and it frequently is not. It is not due to muscle tension as paralysis of pericranial musculature with botulinum toxin fails to give relief. Some authors consider it part of a spectrum of headaches that range from classical migraine through to tension-type headache, as many of the same pathophysiological processes underlie these headache types. Perhaps the term non-specific headache would be more relevant and less prejudicial. Tension-type headache can respond to 10-25 mg amitriptyline at night.

In recent years the entity of chronic daily headache (CDH) has been recognised. This consists of headache for at least 15 days a month during the previous six months. Commonly it is a transformed headache, 78% from migraine, 13% from chronic tension-type headache and only 9% are new daily persistent headache. The transformation into CDH is usually due to excessive analgesic, ergotamine or, controversially, sumatriptan usage. Patients are often taking far in excess of the 50 g of paracetamol or other analgesics per month which can cause CDH. Mixed analgesic compounds are probably the stronger inducers of CDH. Aspirin alone probably is the least likely to induce CDH and a daily dose of 300 mg can have a role in migraine prophylaxis. Excessive analgesic usage nullifies the beneficial effects of concomitant prophylactic agents. Three-quarters of patients with CDH will have a significant improvement in their headaches over a six-month period if they withdraw daily symptomatic medications and initiate prophylactic migraine therapy. Patients should be warned that the analgesic wash-out time may be prolonged; 66% improve significantly after one month, 81% after two months. As well as advice and support on reducing analgesic dependence, patients should be given migraine prophylaxis, where appropriate, and general life-style advice, with particular emphasis on avoidance of precipitating foods, stress reduction and exercise.

Many in the UK will remember the advice of the television advert: ‘Tense nervous headache – take Anadin’. If you walk into any pharmacy you will see rows of various analgesics aimed primarily at the headache sufferer. The epidemic proportions of CDH in our communities can be partially attributable to effective marketing by the pharmaceutical industry. Perhaps it is time for all analgesic packets to have a prominent health warning that ‘Daily use of pain killers can make headache worse’.

Developments in the classification of headaches have allowed us to look at headache afresh and identify specific groups of patients in whom intervention can be helpful. The importance of a name lies in its semantic associations. When those semantic attachments include a better way to manage many of our patients, then the reclassification and reconceptualisation of a common disorder like headache can be important.

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