## 8.2 Headache

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Headache is an extremely common symptom in the general population, and patients with headache present to the emergency department with moderate frequency. It is the task of the emergency physician to try to differentiate those causes of headache that pose a serious threat to the patient's life or health from those that present a painful nuisance.

**History & Examination**

- Two kinds of clues can indicate that a patient's headache may represent a serious threat to life or health: abnormal mental status and abnormal vital signs. For example, fever in the presence of headache makes one immediately suspect an intracranial infectious problem such as meningitis.

### Headache history

- Time relation: time to maximal intensity; frequency; duration
- Prodrome: correlation to menses or medications
- Precipitating or exacerbating factors: exertion, food, position, drugs
- Relieving factors: darkness, position, scalp compression, medication
- Intensity of pain
- Location of pain: unilateral, bilateral, facial, frontal, occipital, neck
- Associated symptoms: loss of consciousness, nausea, vomiting, photophobia, flushing, lacrimation
- Medical history: cancer, travel, trauma, drugs, hypertension
- Family history: headache
- Occupational history: contact with solvents, vapours, carbon monoxide, or chemicals

**Examination**

This should be thorough and include
A
B
C
Central Nervous system including assessment of the coma score
Peripheral nervous system
Temperature
Head to toe examination looking for additional clues such as a rash, neck stiffness and sites of referred pain etc

**Differential Diagnoses**

1.Migraine
2.Tenskion type headache-
  episodic
  chronic
3.Cluster headache
4.Functional headaches
  post traumatic

exertion
coital
drug induced

5. Raised ICP
SOL
Hydrocephalus
BIH

6.Vascular headaches
Subarachnoid
Arteritis
Acute hypertension

7.Inflammatory or infectious
Meningitis or encephalitis
Systemic infections

**MIGRAINE WITHOUT AURA (COMMON MIGRAINE)**

**A.** Duration 4-72 hours

**B.** Two or more of the following:

1. Unilateral location
2. Pulsating quality
3. Moderate to severe intensity
4. Aggravated by routine physical activity

**C.** At least one of the following:

1. Nausea and/or vomiting
2. Photophobia and phonophobia

**D.** Five or more attacks fitting the above criteria

**E.** Exclusion of secondary cause of headache

**MIGRAINE WITH AURA (CLASSIC MIGRAINE)**

**A.** At least three of the following:

1. One or more fully reversible aura symptoms indicating brain dysfunction
2. One aura symptom developing in at least 4 mins,or two or more symptoms in succession
3. No aura symptom lasting over one hour
4. Headache follows aura within one hour

**B.** At least two attacks fitting the above criteria

**C.** Exclusion of secondary cause of headache

**AURAS**

| | |
|---|---|
| • Positive scotomas | • Aphasia/unclassifiable speech difficulty |
| • Negative scotomas | • Visual or auditory hallucinations |
| • Teichopsia/fortification spectra | • Diplopia |
| • Photopsia (flashing lights) | • Ataxia |
| • Homonymous visual disturbance | • Vertigo |
| • Unilateral paresthesias/numbness | • Syncope |
| • Unilateral wea | • Hyperosmia kness |

**Treatment**
A:if the patients conscious level is decreased this may be at risk
B: assess and manage
C: assess and manage

Patients who present to the A&E Department with a headache generally fall into three categories.
1 Those who have developed an **acute severe headache with no past medical history** of note. These patients **need thorough evaluation and should not be sent home** until they are pain free and an adequate explanation for their headache can be found.
2 Those patients with chronic headaches where there has been a recent change in the symptoms. These patients usually need a good evaluation together with analgesia and can be followed up in the out-patient department or GP.
3 Individuals with chronic headache that are no longer responsive to standard medical treatment. These patients should be referred back to their GPs.
See individual sections for more detailed treatment

**Tension headache**
This is the commonest type
Pain is usually pressing or tightening and is bilateral. It may last for minutes to days
Or even months And is not associated with nausea although anorexia may occur. Treatment with analgesics is not usually successful, although explanation, reassurance and relaxation techniques is effective

**Migraine:**
Consider simple interventions first. Proclorperazine (12.5mg IM) and aspirin 900mg orally is a powerful first line combination for patients presenting with an acute migrainous attack. If the patient requires further therapy, they probably need admission to exclude more serious pathology (SAH).

**Cluster headache**
This occurs predominately in young adult men and is characterised by severe constant unilateral supraorbital or temporal pain lasting from 15 mins to 3 hrs.The pain is associated with conjunctival or nasal injection ,lacrimation , rhinorrea, ptosis meiosis or eyelid edema.
Treatment is difficult but pizotifen, methysergide, and lithium have all had some success

**Key points**

- **Never underestimate a headache.** It can often be the presentation of a potentially fatal disorder.
- Always seek characteristic historical clues. Never neglect to palpate the head (temporal arteritis) and to look at the fundi.
- **Do not discharge anybody who has had a sudden onset of headache or who has previously suffered from chronic headaches, but in whom the symptoms have changed.**