

A Big Headache

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ABSTRACT

Aim: To determine the causes and clinical presentations of headache.

Methods: This prospective observational study included 30 patients of headache and carried out at Department of Neurosurgery, Hayatabad Medical Complex, Peshawar from June 2011 to December 2012. Patients having intra-cranial Headache were included. Those patients who have extra-cranial Headache were excluded.

Results: There were 16 patients have cluster headache and 14 patients have tension headache, pain sinusitis headache, ophthalmologic headache and referred headache. Overall results, a big headache 99.5% in female while 88% in male.

Conclusion: The study confirms that headache is a common problem in our adult population.

Key words: Big headache, intracranial pressure, clinical presentation, causes

INTRODUCTION

The public health importance of headache disorders is often overlooked, probably because of their episodic nature and the lack of mortality recognized to them. Headache disorders are, however, often devastating, with considerable impact on social activities and work, and may lead to significant utilization of drugs.¹ Headache imposes a large socio-economic burden on the population. Despite its relatively high point prevalence, a large proportion of headache sufferers are never diagnosed or treated.²

The most common types of headache are the "primary headache disorders", such as tension-type headache and migraine. They have typical features; migraine, for example, tends to be pulsating in character, affecting one side of the head, associated with nausea, disabling in severity, and usually lasts between 3 hours and 3 days.³ Rarer primary headache disorders are trigeminal neuralgia a shooting face pain, cluster headache severe pains that occur together in bouts and hemicrania continua a continuous headache on one side of the head.⁴

Treatment of a headache depends on the causal etiology or cause, but frequently involves analgesics. One of the first published attempts was in 1951.⁵ The National Institutes of Health developed a classification system in 1962.⁶ Headaches are most systematically classified by the International Headache Society's International Classification of Headache Disorders (ICHD), which published the second edition in 2004.⁷ The International

Classification of Headache Disorders (ICHD) is a thoroughly hierarchical classification of headaches published by the International Headache Society. It contains explicit diagnostic criteria for headache disorders. The first version of the classification, ICHD-1, was published in 1988.⁸ Current revision, ICHD-2, was published in 2004.⁷

There are over 200 types of headaches, and the causes range from harmless to life-threatening. The description of the headache, together with findings on neurological examination, determines the need for any further investigations and the most appropriate treatment.⁹ There are however two types of treatment for chronic headaches i.e. acute abortive treatment and preventive treatment. Whereas the first is aimed to relieve the symptoms immediately the latter is focused on controlling the headaches that are chronic. For this reason the acute treatment is commonly and effectively used in treating migraines and the preventive treatment is the usual approach in managing chronic headaches. The primary goal of preventive treatment is to reduce the frequency, severity, and duration of headaches. This type of treatment involves taking medication on a daily basis for at least 3 months and in some cases, for over 6 months.⁷ The medication used in preventive treatment is normally chosen based on the other conditions that the patient is suffering from. Generally, medication in preventive treatment starts at the minimum dosage which increases gradually until the pain is relieved and the goal achieved or until side effects appear.¹⁰

PATIENTS AND METHODS

This descriptive and analytical population-based study included 30 patients of headache and carried out at Department of Neurosurgery, Hayatabad Medical Complex, Peshawar from June 2011 to

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December 2012. Patients having intra-cranial Headache were included. Those patients who have extra-cranial Headache were excluded. The evaluation and management of adult patients who have a non-traumatic headache of acute onset were set according to the guidelines of The American College of Emergency Physicians. While headaches are most likely to be primary non serious and self-limiting, some specific secondary headache syndromes may demand specific treatment or may be warning signals of more serious disorders. Differentiating between primary and secondary headaches can be difficult. When the headache does not clearly fit into one of the recognized primary headache syndromes or when atypical symptoms or signs are present then further investigations with the help of neuroimaging non-contrast head CT was done.

RESULTS

There were 30 patients of big headache. Among them 16 patients(53.3%) of vascular are cluster headache and 14 patients (46.7%) have tension headache, pain sinusitis headache, ophthalmologic headache and referred headache were noted (Table 1). Table 2 showed the causes and area among males and females according to age-wise. Overall results, a big headache 99.5% in female while 88% in male.

Table 1: Frequency and percentage of patients according to headache pain

Pain	No.	%
Cluster headache	16	53.3
Tension headache, pain sinusitis	14	46.7

Table 2: Presentation of causes and area according to age

Age (years)	Sex		Area	Causes
	M	F		
45-53	-	+	Parasagittal meningioma	Brain tumour
	+	-	Frontal glioma	
5-10	+	+	Congenital or acquired	HCP
	+	+	Head injury	Fall/RTA/Blue
10-65	+	+	Higher or poor community	Congenital or acquired migraine
45-65	+	+	Higher community	Sub-arachnoids hemorrhage brain
25-65	+	+	Spinal myelography, spinal surgery CSF leak	Spinal headache
20-65	+	+	Post-craniotomy	Postop headache

DISCUSSION

The headaches are often considered to be a potentially ominous symptom. However, there is substantial clinical, anatomical, biological, and physiologic evidence to support an intrinsic association between the normal physiology of sleep and the genesis of headache in biologically predisposed individuals.¹¹ Headache is a common complaint in primary care practice, and is the third most common patient complaint reported in chiropractic practice. Though frequently episodic in nature and not associated with mortality, headache is also one of the most common human health experiences¹².

Headache disorders are generally classified as either primary or secondary, and these classifications are further divided into exact headache types. Primary headache disorders are not associated with an underlying pathology and include migraine, tension-type, and cluster headache. Secondary headache disorders are recognized to an underlying pathological condition and include any head pain of infectious, neoplastic, vascular, or drug-induced origin^{13,14}.

When a patient develops a headache for the first time with or shortly after head trauma and this headache persists for months or longer, few would disagree with a diagnosis of persistent post-traumatic headache. A de novo headache of this kind, happening in close temporal relation to another disorder that is an accepted cause of headache, was recognized in the 1988 classification.⁸

In recurrent unexplained headaches keeping a headache diary with entries on type of headache, associated symptoms, precipitating and aggravating factors may be helpful. This may reveal specific patterns, such as an association with medication, menstruation or absenteeism or with certain foods.¹⁵ During headache attacks, individuals with headache were being impacted by headache via, for example, pain, decrease in functioning, psychological distress, and decreased vitality^{16,17}.

This is the population-based and face-to-face survey of all headaches in the Pakistani population. The prevalence rate of headache was 53.3%. The overall impact of headache is to decrease the sufferers' quality of life. By becoming aware of these diagnostic pitfalls and being more careful and deliberate in diagnosing headache and other headache types, health-care providers can improve the diagnosis of migraine and help patients to receive suitable therapy.

CONCLUSION

Headache disorders comprise a public health problem of huge proportions, with an impact both on the individual sufferer and on society. Epidemiological knowledge is required to quantitate the consequence of these disorders. Their effects on individuals can be assessed by examining incidence, distribution, attack frequency, and headache related disability.

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