



Clinical Assessment of Headache

Overview

Headaches are classified by the International Headache Society as primary or secondary headaches (<http://www.ichd-3.org>).

The majority of headache is primary (such as migraine). Primary headache is the best validated within this classification system (<http://www.ichd-3.org>).

Secondary headaches are precipitated by another condition or disorder, local or systemic. Serious causes of secondary headache are uncommon.

How to differentiate primary from secondary headache

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The most consistent indicators for serious secondary headache are:

- Thunderclap (sudden onset) headache⁴⁻⁶
- Associated focal neurological deficit^{4,7,8}
- Associated systemic features^{4,7,8}
- Patients over the age over 50 years^{9,10}

The history is the key to diagnosis in headache. The neurological examination is also helpful in differentiating primary from secondary headache.

For example, patients with migraine (with or without typical aura) or tension-type headache and a normal neurological examination do not have an increased likelihood of a secondary precipitant relative to the background population.

For other isolated headache syndromes with normal neurological examination there are insufficient data to enable a definitive conclusion.



Using the temporal pattern of headache to help differentiate primary from secondary headache

We have tried to base this round the different temporal clinical patterns that the 'jobbing' clinician might frequently encounter and recognise.

Sudden onset headache

Sudden onset headache reaching maximum intensity within 5 minutes is called thunderclap headache. Thunderclap headache has the greatest probability of a secondary precipitant.

Recent onset and progressive headache

Evolution of headache over days to weeks. If associated systemic features and/or focal neurological signs there is an increased probability of secondary precipitant.

Recurrent episodic headache

Recurrent episodic headache in isolation is most likely due to a primary headache disorder.

Headache which occurs on the majority of days in a month

Headache present for at least 15 days per month for over 3 months in isolation is most likely due to a primary headache disorder



Differentiating between common primary headache disorders

Laterality and site of headache

Strictly unilateral (right or left but never bilateral) headache most consistently occurs in the Trigeminal Autonomic Cephalalgias (TACS) 11.5- 20% of migraine sufferers experience unilateral headache

Bilateral headache more commonly occurs in migraine, and is a more consistent defining feature of tension-type headache

In most primary headache disorders the pain is experienced in the distribution of the first division of the trigeminal nerve and second cervical root. Neck pain can therefore be a feature of a migraine attack.

Associated symptoms

Prominent features in migraine include nausea, vomiting, photophobia, phonophobia and motion sensitivity (a tendency for the headache to be exacerbated by head movement or mild exertion).

Cranial autonomic features, such as lacrimation, conjunctival injection, rhinorrhoea, and nasal blockage, are characteristic of the TACs, but can occur in up to 25% of migraine sufferers.

Unlike migraine sufferers who are frequently motion sensitive and generally prefer to remain still during an attack, patients with cluster headache and to a lesser extent TACs tend to be restless during an attack.

Aura can be experienced in all headache disorders, but is by far most common in migraine.

Duration and Frequency

The majority of untreated migraine headaches last between 4-72 hours

Untreated TACS are typically of shorter duration and with higher attack frequency