

Headache Disorders: Clinical Features, Approaches to Diagnosis, Specific Treatments

JULIE ROTH, MD
GUEST EDITOR

Migraine is a prevalent neurological disorder, but its prevalence is probably greater among practicing neurologists. I was about twelve years old when I had my “first and worst” headache – triggered, in retrospect, by eating an entire box of chocolates with my grandmother just hours earlier. There I was in the hotel room, a throbbing and ever-intensifying pain creeping over my left eyebrow toward the temple, curled in a ball, intensely nauseated, with a blanket over my head to block out light, and the sound of my parents’ voices only intensifying the agony I felt. If the pain hadn’t gone away with sleep, I am certain I would have also had my first head CT, and possibly my first lumbar puncture. Though we have all learned again and again the typical “red flags” for headache, any migraineur will have experienced at some point in life a “first,” and invariably a “worst.” Yet the needle in the haystack may be the aneurysm rupture, the obstructive hydrocephalus. Scarier still, severity of pain does not always match severity of disease – more often than not, the opposite is true. To a neurologist, a two-month history of personality changes and mild left-sided weakness with a dull, “two out of ten” headache is more frightening than a “ten out of ten” headache with nausea and vomiting in a young woman of childbearing age, especially if further history suggests a gradual onset, perimenstrual headaches, and a strong family history of migraine. Sorting through all those headaches invariably produces... headache. For many practitioners, the angst about headache is angst about missing a secondary cause. For others, it is the discomfort with treating chronic pain, or unpacking its psychosocial baggage.

This issue of the *Rhode Island Medical Journal* aims to alleviate the provider’s headache, by shedding more light on headache – from accurate diagnosis to specific treatments.

DR. NORMAN GORDON has practiced general neurology in Rhode Island for more than 20 years; in **Clinical Features of Migraine and Other Headache Disorders**, he shares wisdom gleaned in his Miriam Hospital-affiliated private practice, illustrating the importance of making an accurate diagnosis as a crucial first step in the proper management of some common and uncommon primary headache disorders.

In **Chronic Daily Headache: Challenges in Treatment**, **DRS. JAY LEVIN AND MICHELLE MELLION** (of Rhode Island Hospital, The Neurology Foundation) provide a comprehensive review of one of the most tormenting conditions

encountered by practitioners, touching on its diverse comorbidities, and treatment principles. By the end of the article, I assure you, the condition will be far less scary.

DR. LUCY RATHIER is a psychologist (of Lifespan Physicians Group) specializing in the behavioral treatment of medical conditions, particularly headache. Our article, **A Biobehavioral Approach to Headache Management**, provides the foundation for a collaborative, multifaceted approach to headache management, demonstrating a rationale for combining behavioral techniques with more typical medications – particularly for those headaches that have become chronic.

DR. NIHARIKA MEHTA, a specialist in obstetrical medicine at Women and Infants Hospital, has written an insightful case-based article, **Headaches in the Pregnant Patient**, which highlights challenges in diagnosing and treating headache in a pregnant patient – pregnant women being yet another anxiety-provoking population.

Pain is meant to signal the brain when something is wrong with the body. Yet in primary headache, that signal goes haywire, and the brain needs to be taught to stop listening to the false signal. Cut to two and a half years ago: pregnant with my daughter, I noticed an odd disturbance in my left peripheral vision – an alternating pattern of brightly lit, rainbow colors, shaped like a zigzag, with a glistening inner edge. It flashed on and off for fifteen minutes, then vanished completely. If it hadn’t been for my interest and knowledge of migraine, I might have panicked, inevitably intensifying the pain that followed. Instead, I waited it out. The descending pathways of my periaqueductal gray area kicked in, and I was fine. By linking clinical features and mechanisms with management strategies, we hope you will not be afraid to unpack the baggage – both physiologic and psychosocial – and appreciate that the diagnosis and treatment of headache can be among the most rewarding in medicine.

Author

Julie Roth, MD, is a Neurologist at The Neurology Foundation, Providence, RI; and is Assistant Professor, Department of Neurology, the Warren Alpert Medical School of Brown University.