Chronic daily headaches: a transformation

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Risk factors for CDH are summarised by the 5Fs: Frequent analgesic use (two to five fold risk), Fearful (anxiety, stress), Female (four fold), Forties (middle-age), Fat (overweight, fivefold risk). Other risk factors include sleep disturbance, OSA, smoking, Caucasian race, family history and low socioeconomic status.

CDH is essentially a 'transformed' ('sensitised') form of precursor headache, usually migraine, or a tension-type headache (TTH) or cervicogenic headache (e.g. post-whiplash) and more rarely, cluster-vascular headaches. There is a rare form of CDH known as 'new daily persistent headache' which usually affects young adults without an obvious cause (viral illness or stressful life events are implicated). NDPH is typified by patients remembering the exact time and circumstances of onset, even years later.

The phenotype of CDH is similar to chronic TTH (diffuse 'whole-of-head', dull, aching, pressure, occasional nausea and sensory sensitivity) with some of the features of the precursor headache.

CDH nearly always leads to medication overuse headache (MOH) (analgesia use on at least 10 days per month) which worsens CDH in a vicious cycle. Medications include triptans, opioids (e.g. codeine), sedatives, ergots, NSAIDs and caffeine. Patients may try to prevent their headaches by taking analgesics pre-emptively (aka withdrawal headache).

Management principles

A multidisciplinary approach is required to manage CDH, particularly clinical psychology to deal with anxiety, stress and habitual medication-use behaviours. Management is difficult with a relapse rate of 30-50%, particularly with outpatient treatments. It helps to inform about CDH and MOH.

Exclude headache 'red flags' ('TINT': Tumour, Temporal arteritis, Intracranial pressure [high or low], Inflammation [meningitis], Neurological deficits, Trauma). MRI or CT cranium, lumbar puncture and manometry or ESR/CRP may be required if 'red flags' indicate a need. Consider other causes of CDH including cervicogenic (post-whiplash), sinus, facial pain/TMJ, trigeminal neuralgia and ophthalmic.

ED. **Affecting 5% of people, chronic daily headaches occur at least 15 days per month and are debilitating, affecting work and frequently leads to medication overuse.**

Identify and manage 'yellow flags': psychosocial stressors, anxiety, sleep, substance and medication-overuse behaviours.

Treat the original precursor headache (nearly always migraine) using amitriptyline, topiramate (migraine) or botulinum toxin injections (chronic migraine). All patients

continued on Page 29

continued from Page 28

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with CDH should have at least one trial of GON (Greater Occipital Nerve) blocks.

It is essential to manage MOH by dose tapering and cessation. Start a medication and headache diary. Try outpatient tapering in a motivated patient (amitriptyline and 10% dose reduction per week). Inpatient management for patients who can't taper at home or at risk of headache flare-up or withdrawal: Five-day admission for GON blocks, amitriptyline, metoclopramide, prednisolone, IV ketamine and rescue analgesia (cranial TENS, indomethacin suppositories, clonidine, ondansetron, lorazepam or clonazepam). Opioid withdrawal may need to be managed concurrently.

Relapse prevention where possible and frequent follow up is vital. ■

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