Woman with Frequent Headaches
Learning Objectives

• At the conclusion of this case, participants should be able to:
  – Recognize chronic migraine and distinguish it from other headache disorders and
  – Be familiar with evidence-based treatment choices for management of patients with frequent headache and/or migraine.
Medical History

- JW is a 47-year-old woman
- Headache occurring virtually daily
- History of migraine without aura since age 16 y
  - Moderate-to-severe intensity
  - Associated with photophobia, phonophobia, and nausea
- Disability: movement made pain worse or exacerbates the throbbing
- Used NSAIDs and ASA for years; @ 37 yo started triptan
Complaints at Clinical Presentation

• 6 months ago, she noticed an increase in migraine frequency
  – 3/wk (about 18 headache days per month)
  – Less severe in intensity
  – Associated with photophobia and nausea
  – Symptoms often worsen with movement or activity

• Difficulty falling asleep and staying asleep
  – Feelings of sleep deprivation
### Medication History

**Medical history**
- Migraine headache - since teen years. Previously tried topiramate and propranolol as preventive therapies without success
- Generalized anxiety
- History of depression
- Peptic ulcer disease
- Hypercholesterolemia

**Current Medications**
- Triptan PRN
- Combination analgesic (AAC) for rescue PRN (< 5/mo)
- Citalopram 40 mg po qd for headache prevention, anxiety and potential depression
- Pantoprazole 40 mg po qd for peptic ulcer disease
- Simvastatin 20 mg po qd for hypercholesterolemia
Family/Social History

Family history

• Father: hypertension, hypercholesterolemia
• Mother: noninsulin-dependent diabetes
• Sister: episodic migraine without aura

Social history

• Married, 3 children (2 home, 1 college).
• Accountant at large firm
Review of Systems

- Complains of fatigue but denies any recent infections or illness
- Weight and appetite have been stable
- No recent or remote history of head trauma
- No SOB, dyspnea, dizziness, or syncope
- No chest pain
- No abdominal pain, vomiting, diarrhea, or constipation
- Denies BRBPR or melena
- Denies hematuria
- Menstrual periods are regular
- Denies arthralgias or myalgias
- Denies focal motor weakness or loss of sensation
- Mood: “frustrated about the headaches”; can’t sleep
- Sexually active but frequent headaches impacted sex drive
Question 1

Which of the following would be useful in the further evaluation of this patient?

- Additional history about medication use
- MRI
- CT
- CBC and laboratory tests
- Additional history regarding sleep, depression and anxiety
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When might MRI and CT be warranted?

“SNOOP”

- **SYSTEMIC SYMPTOMS** (fever, weight loss) or **SECONDARY RISK FACTORS** (HIV, systemic cancer)
- **NEUROLOGIC SYMPTOMS** or abnormal signs (confusion, impaired alertness or consciousness)
- **ONSET**: sudden, abrupt, or split-second
- **OLDER**: new onset and progressive headache, especially in middle age >50 yr (giant cell arteritis)
- **PEVIOUS HEADACHE HISTORY**: first headache or different (change in attack frequency, severity, or clinical features)
Additional Medication History

• Age 30: 4-week course of propranolol 40 mg
  – Followed by 4 week course of 80 mg
  – Discontinued
• Age 43: 1 week topiramate 50 mg/d
  – Escalated to 100 mg/d
  – Discontinued after 2nd week due to paresthesias
• Current medications
  – Citalopram 3 months, no change in HA frequency
  – AAC/NSAIDs 3-5 times per month
• No alcohol or tobacco use; morning caffeine use
  – No exacerbation of HA when not drinking caffeine
Additional Psychosocial History

Additional history regarding sleep and depression

- Difficulty ‘winding down’ at night to go to sleep
  - 30 minutes to 3 hours to fall asleep
  - Awakens around 3:00 am and unable to go back to sleep
  - No snoring or other symptoms of obstructive sleep apnea
  - No symptoms of restless leg syndrome
  - No symptoms of daytime somnolence or narcolepsy

- If she had symptoms characteristic of a primary sleep disorder, a polysomnogram and/or multiple sleep latency test may be appropriate
Question 2:
What is the primary diagnosis for this patient?

- Episodic migraine
- Chronic migraine
- Chronic tension-type headache
- Medication overuse headache
- Caffeine withdrawal headache
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Clinical Course I

• Provided a diagnosis of chronic migraine without aura
• Instructed to identify migraine attacks vs other HA types
• Advised on life-style modifications:
  – Regular exercise
  – Routine meals
  – Regular sleep hygiene
  – Stress management
• Counseled to monitor/restrict daily use of caffeine and other analgesic/rescue medications
  – Reviewed risk of developing medication-overuse headache
  – Restrict to < 2 doses per week
  – Switch to NSAID with no caffeine (eg. naproxen sodium)
Question 3: What migraine preventive medication might be appropriate in this patient?

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- Verapamil
- Atenolol
- Amitriptyline
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For migraine, effective doses of amitriptyline range from 30-100 mg given once at night. To minimize side effects, the patient is started on 10 mg and the dose increased in 10-mg increments every 3-4 days until reaching the target dose (eg. 50 mg). Common side effects include somnolence, weight gain, and orthostatic hypotension.
Question 4: If JW headaches gets worse in the first 3 weeks, what should be done?

- Tell her to increase her use of analgesics and triptans
- Obtain an MRI of the brain
- Change preventive medications
- Focus on good headache hygiene habits and provide reassurance
- Do additional “SNOOP” and repeat exam
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