In the name of God

Refractory Headache : Diagnosis and Management

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Introduction

The definition of refractory headaches, also known as intractable headaches, is still not clearly described. But according the latest guidelines, refractory headaches are known as headaches which markedly affect patients' function or quality of life in spite of triggers modification, lifestyle correction, and adequate trials of acute and prophylactic medications with established efficacy. Moreover, refractory headaches and intractable headaches do not always manifest in the same way. Refractory headaches are thought to improve over time and/or in response to the treatment modalities, while intractable headaches manifest as a condition that seems not be better over time. In the current review, we aimed at collecting available information on dealing with refractory headache patients.

Methods

I searched MEDLINE, and ScienceDirect and used the latest IHS guideline and also reported my personal experiences.

Results

In my experience with the management of more than 30,000 headache patients over the years and my literature review, there are different causes that make a headache refractory.

1.First, misdiagnosed cases due to of different reasons:

A-When a physician cannot get an accurate history. In our headache clinic one of the causes of misdiagnosis in this category is medication overuse headache (MOH) which is sometimes ignored by physicians because some of the headache sufferers do not respond correctly to direct questions regarding their abortive drugs consumption.

B-When a physician ignores the previous history of headache in the patient. For example in chronic migraine headache the history of episodic migraine with gradual accentuation is necessary but sometimes the patients give the history of their recent chronic headache and taking the history of their previous episodic headaches is very difficult and needs more attention.

C-When a physician does not consider the probability of secondary headaches including cervicogenic headaches, spontaneous intracranial hypotension, idiopathic intracranial hypertension without papilledema, oral, nasal or temporomandibular joint disorders which all are among the secondary headaches that are missed by physicians.

2.Improper treatment is another risk factor for RH development in patients. It is very important to titrate prescribed medications to the maximum tolerable dosage and wait for at least two months to see if they are effective. Concurrent presence of analgesic overuse is also thought to be common among RH subjects and might cause prophylactic treatment ineffective,.

3.Presence of comorbidities, is another cause for a headache to be considered as refractory. Psychiatric disorders, particularly in adolescent patients, are involved in the progression of headaches and should be treated with high accuracy.

4.Drugs that a patient consumes for the other diseases could also be a reason for susceptibility to RH.

5.In addition, ignoring other modalities of treatment may be another risk factor for refractoriness of headaches. Nerve or ganglion blocks, neurostimulations and surgeries could be promising in the management of difficult to treat patients.

6.Real refractory cases are present but are not as numerous as physicians think.Chronic migraines, chronic clusters, other TACs, and different types of neuralgias might be refractory.

Conclusions

In the approach to a patient with RH, we should first confirm the diagnosis, then choose the best way of treatment by considering her/his co morbidities and optimize the drug dosage. MOH and various psychiatric disorders are important issues that should be taken into account by a neurologist when treats a headache patient. Multidisciplinary clinics with medical staff from different disciplines are recommended to manage the drug resistant patient in a holistic care program. In the cases with poor response to outpatient therapy, or unsuccessful outpatient detoxification for overuse of specific medications (particularly opioids), or in patients with severe psychiatric comorbidities, inpatient management should be considered. Inpatient treatment should include appropriately controlling patient's pain, discontinuing offending drugs in the case of MOH, medical or psychiatric consults for comorbid conditions and initiating the suitable prophylactic therapy.

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