Chapter 6

The History and Examination of Headache Patients

Jes Olesen and David W. Dodick

CLINICAL APPROACH TO PATIENT WITH HEADACHE

For patients with new-onset or progressive headaches, the approach is similar to that of other acute neurologic illnesses. Such headaches may be secondary and the efforts are directed at identification of the cause of the headache and providing treatment for the underlying condition. The approach to headaches that have been recurrent and present for more than 6 months is different.

Patients who present to a primary care physician or neurologist for the first time with a pure migraine or pure tension-type headache are straightforward and need no special approach except a careful history, neurologic examination, proper classification, and appropriate treatment. The general practitioner should know how to identify migraine without aura, migraine with aura, episodic tension-type headache, chronic tension-type headache, cluster headache, and chronic posttraumatic headache. When these conditions are not present, patients should be referred. Likewise, if the general practitioner is not successful after trying two acute or preventive treatments, the patient should be referred to a neurologist or a headache specialist.

Patients who are difficult to treat or who have a rare type of headache are best seen by a neurologist with a special interest in headache. This article is intended for neurologists and other doctors with such an interest. Therefore, we focus on a comprehensive approach that is suitable for difficult headache patients. Before these patients present to a specialist they have often seen several primary care and specialist physicians, have had numerous computed tomography (CT) and/or magnetic resonance imaging (MRI) scans, and have seen psychologists or psychiatrists, ear, nose, and throat specialists, ophthalmologists, or other specialists. They are often quite desperate because their headaches significantly impair their work-related productivity, and impose a significant burden on their social, family, and leisure activities. In many cases, past consultations have not resulted in a thorough history or neurologic examination and treatment results have been disappointing. Some of these patients are understandably alienated from the medical system.

The first task for the headache specialist is to display real interest in the patient and to make them understand that their problem is being taken seriously. In practical terms, this means taking an extensive general history and a detailed headache history, as well as performing a general and a neurologic examination with emphasis on headache-relevant aspects.

Even though migraine is a highly prevalent and disabling medical condition for which unambiguous operational diagnostic criteria are available (3), it is still frequently misdiagnosed. In a recent population-based study, 52% of the patients who fulfilled the International Headache Society classification criteria for migraine did not receive the correct diagnosis (13). Of those who received an inaccurate diagnosis, 42% received a diagnosis of sinus headache and 32% received a diagnosis of tension-type headache. Although the reason for such misdiagnoses is unclear and is probably multifactorial, the frequent presence of symptoms such as nasal congestion, lacrimation, rhinorrhea, and neck stiffness and pain during migraine attacks likely contribute to this problem (1). In addition, several common migraine triggers such as stress, changes in weather, and high altitude may lead a physician to one of these alternative diagnoses. Tension-type headache, even chronic tension-type headache, is also underdiagnosed (19).

GENERAL HISTORY

The family history of headache is important. This is especially true in migraine, where there is a 4-fold risk for