Chronic Daily Headache - 2010

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Introduction

Chronic daily headache (CDH) is a syndrome, not a diagnosis. It simply means headache on more than 15 days a month, in other words, headache more often than not. CDH is incredibly common; epidemiological studies show an overall prevalence of between 2-7% in developed countries, suggesting that in the UK between 1 and 3 million people may be suffering from this condition.

There are a number of primary and secondary headache disorders that can cause chronic daily headache (see Table 1). CDH may evolve from a previously episodic headache disorder, usually migraine, often driven by overuse of acute medication or caffeine, psychological co-morbidities (already existing conditions) such as anxiety or depression, physical conditions such as sleep apnoea, or significant life events. The key technique in making an accurate diagnosis for patients with CDH is to discover how the headaches began, and what they were like when they began, especially as chronic headaches tend to lose their specific features over time.

Medication overuse headache

Medication overuse is extremely common in patients with CDH. As many as 50% of patients fulfil the diagnostic criteria of: chronic headache that has developed or worsened with the regular overuse of analgesics. These comprise: Ergots, triptans, opioids, or combination analgesics for more than 10 days/month or simple analgesics on more than 15 days/month. Worldwide the prevalence of medication overuse headache may be between 0.5-1%; this number rises to 60-85% of all new referrals to tertiary headache centres. The idea that medication overuse can cause chronic headache has become generally accepted after the publication of studies showing that frequent use of analgesics for non-headache disorders causes CDH only amongst patients with personal or family histories of migraine. Equally widespread clinical experience has shown the improvement that patients can experience by undergoing medication withdrawal.

Medication overuse may be driven by various psychological factors, including the natural desire to relieve pain and continue functioning, the fear of headache, obsessional drug-taking behaviours, (rarely) psychological drug dependence, and most commonly and most difficult to address: the necessity to take painkillers for other pain conditions. Abrupt outpatient withdrawal of analgesics may help reduce chronic headache, but it will work only if these psychological factors are acknowledged, and the patient be counselled about their importance.

Medication withdrawal may be very effective. Up to one-third of patients experience a significant improvement in their headaches, reverting to their previous episodic disorder. A further one-third of patients experience a reduction in the frequency or severity of their headaches, and a further one-third experience no improvement. For these patients, however, the process is still important as it not only gives people back control over their headaches, but also allows previously discarded prophylactic treatments to regain their effectiveness.

Primary chronic headache disorders

Patients who have successfully dealt with medication overuse may be left with chronic headaches. The nature of these headaches may be clearer once they are not taking analgesics regularly. The commonest primary diagnosis is chronic migraine, but cases of chronic cluster headache, hemicrania continua, and chronic paroxysmal

hemicrania may emerge from previously unclassifiable chronic headaches.

Chronic migraine may be treated with the usual selection of prophylactic treatments (see the next article). Chronic cluster headache may respond to verapamil, topiramate, lithium, methysergide, or melatonin. Chronic paroxysmal hemicrania or hemicrania continua should respond to indometacin. All the chronic trigeminal autonomic cephalgias have been shown to respond to occipital nerve stimulation in a reasonable proportion of cases.

New daily persistent headache

In the last 15-20 years a new category of headache disorders has been recognised. These are the new daily persistent headaches, that is, headaches simply starting one day and not going away. Some patients have a pre-existing headache disorder, but the cardinal feature of new daily persistent headache (NDPH) is that it emerges *de novo* without any sense that it has evolved out of a previous disorder. Recognising NDPH is important as within this category you will find some of the serious causes of headaches that most concern patients, GPs, and headache specialists (see Table 2). Many of the headache disorders that come under this heading need specific treatments.

Conclusion

CDH is a common problem in general practice, general neurology clinics, and specialist headache clinics. Although CDH patients are often the most challenging to deal with, accuracy in diagnosis and perseverance in treatment can lead to significant improvements in virtually all cases.