Men don't get headache – do they?

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The majority of troublesome headaches will be migraine, which is not difficult to diagnose and there are a number of effective treatment options. Although migraine headaches are more common in women, a significant number of men do experience them, but men are less likely to seek help from their GP.

Headache is often stigmatised and many patients do not consult because of poor previous experience. The majority of adult migraineurs have never consulted their GP, in spite of high levels of disability.1 Of those who do consult, most have only a single consultation for headache and for many, pharmacists and opticians are alternative options for advice.

Although migraine has a high impact – it is in the top 20 of the World Health Organization diseases in terms of disability-adjusted life years (a measure of the degree of disability and time spent with it) – the needs of headache sufferers go largely unmet.2 Only 4% of GP headache presentations are referred to secondary care, but headache is the most common reason for consultation for neurology.3

The reasons for poor consultation rates are unknown but may include a belief that nothing can be done, stigmatisation of headache, or poor previous experience with headache consultations. Many migraineurs may be unaware that their headache is migraine. This is a particular problem with men, where the suggestion is that headache is a reflection of inability to cope. However, a significant number of males suffer from migraine, particularly at the time of maximum social and economic demand (Figure 1).

Although cluster headache affects only 0.1% of the population, it is arguably the most painful condition known to medicine and the majority of sufferers are males.4

MAKING THE HEADACHE DIAGNOSIS

The two major classifications of headache are: primary, where there is no identifiable underlying disorder; and secondary, where an underlying cause can be identified (Box 1). Five per cent of headaches presenting to the GP will be secondary and these must be excluded as a first step (Box 2).

Inevitably, there is always an underlying concern that a headache presentation reflects an underlying pathology. When an adult patient presents to his or her GP with headache, the risk of a brain tumour is 0.09%.5 Physicians must not overlook the deleterious impact of identifying incidental findings on health.6

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Imaging, which in GP studies have been up to 10% of those imaged. It is important to image only when there is a clear indication and not for the alleviation of anxiety alone.6

MIGRAINE

Diagnosing migraine
Migraine is the most likely cause for headache presentations in primary care. Thirty percent of migraine is associated with aura. This is a transient focal sensory or motor neurological deficit that usually precedes headache and should not last for more than 60 minutes. The formal criteria for a diagnosis of migraine are shown in Box 3, but a positive answer to two of the following three questions has a high sensitivity and specificity:7

- recurrent headaches that interfere with function
- nausea with headache
- light bothers with headache more than when headache is absent.

Many migraine sufferers will also have medication-overuse headache, which can make diagnosis difficult if this is not excluded. The problem arises with analgesic intake $\geq 15$ days per month. Opioid compounds and in particular codeine are particularly implicated. Triptan-overuse headache requires only 10 days’ use per month. There is no evidence-based guidance for treatment, but abrupt cessation seems the best option, with introduction of preventive medication for

BOX 1. Main categories of primary and secondary headache

MAIN PRIMARY HEADACHES
- Migraine
- Tension-type headache
- Cluster headache and other trigeminal autonomic cephalalgias

MAIN SECONDARY HEADACHES
- Headache attributed to head or neck trauma
- Headache attributed to cranial or cervical vascular disorder
- Headache attributed to non-vascular intracranial disorder
- Headache attributed to a substance or its withdrawal
- Headache attributed to infection
- Headache attributed to disorder homeostasis, eg renal failure, thyrotoxicosis
- Headache or facial pain attributed to disorder of cranium, neck, eyes, nose, sinus, teeth, mouth or other facial or cranial structures
- Headache attributed to psychiatric disorder
- Cranial neuralgias and central causes of facial pain

IMMEDIATE ASSESSMENT REQUIRED
- Thunderclap headache (including orgasmic headache)
  - severe headache rising to maximum crescendo within a minute
  - worst-ever headache
  - exclude subarachnoid haemorrhage
- Headache associated with possible meningoencephalitis
- Headache associated with malignant hypertension
  - retinal changes
  - blood pressure $>200\text{mmHg}$ systolic, $120\text{mmHg}$ diastolic
- Headache associated with significant head injury

URGENT ASSESSMENT REQUIRED
Urgent investigation or urgent neurology referral
- Temporal arteritis
  - always consider in patients over 50 years
  - inflammatory markers are normal in 5% of cases
  - may need urgent biopsy to confirm
- Exercise headache
  - 10% will have a secondary cause
- Carbon monoxide poisoning
- non-specific headache
- enquire re heating devices
- Space-occupying lesion

RED FLAGS (RISK $>1\%$)
Image/scan or refer to neurologist
- Associated relevant neurological signs
- Associated with new-onset seizure
- History of cancer elsewhere

ORANGE FLAGS (RISK $>0.1–1\%$)
Need careful monitoring and low threshold for image/scan or referral to GPwSI or neurologist
- Significant unexplained change in headache character
- Migraine aura $>1$ hour
- Headache precipitated by Valsalva manoeuvre
- New headache in a patient older than 50 years
- Headache that wakes from sleep (not migraine or cluster)
- Headache where diagnosis cannot be made 8 weeks from presentation
- Immunosuppressed or HIV

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the most likely underlying headache type, invariably migraine. Identification and careful explanation of the nature of the problem and positive support are essential.

**Acute treatment of migraine**

In 2012 NICE published guidelines on the management of headache. Aspirin (900mg) is a simple starting point, but ideally a combination of a triptan, a non-steroidal anti-inflammatory agent and paracetamol is more effective. An anti-emetic should be used even in the absence of nausea and vomiting, as there will inevitably be a degree of gastric stasis compromising absorption.

An important point is that failure of response to triptans is not a class effect and if one triptan does not work, there is an 80% chance that another will. The key to the acute attack is early treatment. If vomiting is problematic, a nasal or injectable triptan can be used.

**Preventive treatment of migraine**

The impact on the patient's quality of life is the best guide as to when to start preventive treatment. Beta-blockers and topiramate are the drugs of first choice recommended by NICE. Gabapentin is an alternative evidence-based option. Medication should be taken for at least eight weeks before benefit can be assessed. Amitriptyline, although not supported by evidence and not recommended, should be continued if a patient is already taking it. It is likely that headache experts will continue to use this drug, particularly where anxiety, depression or poor sleep is a problem.

The differences between migraine and tension-type headache are shown in Table 1. In many cases, tension-type headache sits on the migraine spectrum and has similar underlying mechanisms.

**Cluster Headache**

A cluster headache is a single attack lasting on average 60 minutes, whereas a cluster period is an episode during which there are frequent cluster headaches, following which the individual is in remission. The average cluster period lasts between 6 and 12 weeks, but there is considerable variation between patients. A common pattern, especially in the first few years of a cluster headache, is for exacerbations to occur seasonally, usually in spring and autumn. The reason for this is unknown. However, a small number of patients get chronic cluster headache, where there are remissions that last less than 14 days. Important differences between migraine and cluster headache are shown in Table 2.

For the acute attack, where the cluster period is short, prednisolone is a useful option. Other acute therapies include injectable sumatriptan and 100% oxygen. For prevention, verapamil is the treatment of choice, but doses have to be higher than the licensed maximum.

**Conclusion**

Primary headache has a significant impact upon men, whose needs are largely unmet. The majority of troublesome headaches will be migraine, which is not difficult to diagnose and there are a number of effective treatment options. The first important step is to encourage men to seek help from their GP.

Declaration of interests: none declared.
Migraine | Cluster headache
---|---
Pain can occur in any location | Pain is periorbital
Pain is severe and throbbing | Pain is very severe and piercing
Patient wants to lie down | Patient paces the room
Attacks last 4–72 hours | Attacks last 15–180 minutes and come in clusters
No autonomic features | Autonomic features around the eye on side of pain
Nausea, vomiting, photophobia or phonophobia | Rare

Table 2. Important differences between migraine and cluster headache

USEFUL RESOURCES

- SIGN (www.sign.ac.uk) and NICE (NICE.org.uk) guidelines offer reviews of evidence-based headache care
- The British Association for the Study of Headache (www.bash.org.uk) provides pragmatic UK headache management guidelines
- Exeter headache clinic web site (www.exeterheadacheclinic.org.uk) contains clinical guidance and comprehensive patient information treatment sheets that can be downloaded
- Useful information can be obtained from patient support groups on:
  - Migraine Action (www.migraine.org.uk)
  - Migraine Action (www.migraine.org.uk)

REFERENCES