Expert Opinion

Posttraumatic Hemicrania Continua?

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Posttraumatic headaches can take many forms.

CLINICAL HISTORY

This 34-year-old woman has had recurring headaches since aged 16 when she was assaulted and hit multiple times on the head with a wrench. There may have been brief loss of consciousness. A CT scan of the head was negative. She describes a right frontal and right occipital throbbing pain (more intense in the occipital area) with light and noise sensitivity and occasional nausea and vomiting. The headache never occurs on the left side. She denies any conjunctival injection, tearing, ptosis, nasal drainage, foreign body sensation in the eye, or precipitation of the headache with head turning. The headaches last 15 minutes to 4 hours. During the last month, the headaches have been occurring five to six times daily. Previously, the headaches were occurring about twice weekly. About 7 years ago, she was headache-free for 2 months. The headaches occasionally awaken her from sleep. Neurological examination is normal. The suboccipital region is nontender.

She has seen two neurologists previously. She has had four MRI scans of the head over the years with normal findings. Until about 3 years ago, she was on amitriptyline, 200 mg, at night for approximately 5 years which reduced the frequency of the headaches. Midrin, sumatriptan, and rizatriptan have not helped. Hydrocodone bitartrate and acetaminophen (Vicodin) and dihydroergotamine mesylate (Migranal) are of mild help. Propranolol did not help. Depakote caused a rash. Tolmetin sodium did not help and upset her stomach.

Questions.—What is the diagnosis? Could this be posttraumatic hemicrania continua despite the absence of autonomic accompaniments? What treatment would you suggest?

EXPERT COMMENTARY

Chronic headache following trauma to the head or neck is well described, with the duration of headache being independent of the type or severity of trauma.[1] The International Headache Society (IHS) classification includes acute posttraumatic headache (which resolves after 8 weeks), chronic posttraumatic headache, and worsening of preexisting migraine or tension-type headache following trauma.[2] The majority of patients improve within 6 months, with approximately 18% of patients experiencing more chronic headache.[3] Much debate exists in the literature regarding posttraumatic headache, and thus, diagnosis and treatment are often on a trial-and-error basis and frequently pose difficult management dilemmas. Analgesic overuse must be ruled out as a contributing factor.[1]

Hemicrania continua is a rare, benign headache disorder described as a unilateral continuous headache, with superimposed exacerbations of more severe pain. During these painful attacks, autonomic features (ptosis, lacrimation, conjunctival injection) may appear. Other features may include photophobia or phonophobia or both, nausea, and ocular dis-

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comfort. A dramatic response to indomethacin (25 to 300 mg daily) is felt to be a sine qua non of diagnosis.[4]

This patient may have posttraumatic hemicrania continua, and a trial of indomethacin is certainly warranted. Her history is somewhat atypical in that there is no mention of baseline headache, only the recurrent short-lasting headaches that occur daily. She has no autonomic features. However, when present, these features tend to be much less prominent than in cluster or chronic paroxysmal hemicrania. While no mention is made of analgesic overuse, this must be excluded as a cause of daily headache.

REFERENCES

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FOLLOW-UP

The patient was started on indomethacin, 50 mg, three times a day after food and amitriptyline, 25 mg, at night for 1 week and then increased to 50 mg at night. When seen 1 month later, the headaches had decreased to about every other day with two to three on that day lasting about 1 to 1 1/2 hours. Because of nausea from the indomethacin, she was placed on famotidine and the dose of indomethacin was not increased. Long-acting verapamil, 240 mg, was added as a preventive.