Diagnosing Headache Disorders

VA/DoD Clinical Practice Guideline for the Primary Care Management of Headache

For further information scan the QR code or visit
https://www.healthquality.va.gov/guidelines/pain/headache

HEADACHE TYPES

Tension-type Headache (TTH)

Diagnosis requires:

- ☑ At least 10 headache attacks lasting 30-minutes to 7-days *with*
- ☑ At least two defining characteristics *and*
  - ○ Bilateral location
  - ○ Non-pulsating quality
  - ○ Mild to moderate intensity
  - ○ Not aggravated by routine physical activity
- ☑ Both of the associated features
  - ○ No nausea or vomiting
  - ○ Either photophobia or phonophobia, but not both

If headaches fulfill all but one of the TTH criteria (e.g., having both photophobia and phonophobia), the diagnosis would be probable TTH.

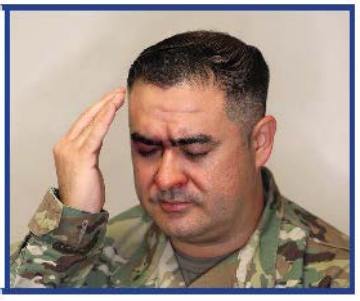
Migraine Headache

Diagnosis requires:

- ☑ At least five attacks lasting 4 – 72 hours *with*
- ☑ At least two defining headache characteristics
  - ○ Unilateral
  - ○ Throbbing/pulsating
  - ○ Moderate or severe intensity
  - ○ Aggravated, or caused by routine physical activity *and*
- ☑ At least one associated feature
  - ○ Nausea and/or vomiting
  - ○ Both photophobia and phonophobia

If headaches fulfill all but one of the migraine criteria (e.g., photophobia or phonophobia, but not photophobia and phonophobia), the diagnosis would be probable migraine.

Cluster Headache



Diagnosis requires:

- ☑ At least five attacks
- ☑ Severe to very severe unilateral orbital, supraorbital, and/or temporal pain
- ☑ Lasting 15 – 180 minutes and
- ☑ Occurring once every other day to no more than eight times a day
- ☑ Either or both autonomic features and a feeling of restlessness/agitation

There are definitions for probable TTH, probable migraine, or probable cluster headache where patients may not fulfill all criteria listed above. The Work Group suggests that providers should not withhold therapy when patients do not meet all criteria listed for TTH, migraine, or cluster headache (i.e., are diagnosed with probable TTH, probable migraine, or probable cluster headache). Providers should continually reassess patients during therapy.

For patients where the clinical presentation is complex (multiple types of headaches present) or presentation does not clearly fit any one primary headache type, referral to a specialist is recommended.

		Tension-type Headache (TTH)	Migraine Headache	Cluster Headache
				
Attack Duration and Frequency	Duration	30 minutes – 7 days	4 – 72 hours	15 – 180 minutes
	Frequency	Variable	Variable	Once every other day to eight per day; often occurring at the same time of day
Headache	Severity	Mild to moderate	Moderate to severe	Severe or very severe
	Location	Bilateral	Unilateral	Unilateral orbital, supraorbital, and/or temporal
	Quality	Pressing or tightening, non- pulsating	Throbbing or pulsating	Stabbing, boring
	Aggravated by routine physical activity	Not aggravated by routine activity	Aggravated by routine activity	Causes a sense of agitation or restlessness; routine activity may improve symptoms
Associated Features	Photophobia and phonophobia	Can have one but not both	Both	Variably present
	Nausea and/or vomiting	Neither	Either or both	May be present
Other Features	Autonomic features: • Conjunctival injection and/or lacrimation • Nasal congestion and/or rhinorrhoea • Eyelid oedema • Forehead and facial sweating • Miosis and/or ptosis	Autonomic features typically absent	May occur, but are often subtle and not noticed by the patient	Prominent autonomic features ipsilateral to the pain (see Appendix A in the full text Headache CPG)

Secondary Headache Disorders Criteria

Criteria for Determining Primary Versus Secondary Headache Disorders

Secondary headaches include:

- Headache attributed to trauma or injury to the head and/or neck
- Cranial or cervical vascular disorder
- Non-vascular intracranial disorder
- A substance or its withdrawal
- Infection
- Disorder of homeostasis
- Disorder of the cranium, neck, eyes, ears, nose, sinuses, teeth, mouth, other facial or cervical structure
- Psychiatric disorder

Initial evaluation of headache should be targeted at determining if there is a secondary cause for the headache or if the diagnosis of a primary headache disorder is appropriate.

Emergent evaluation should be considered based on ***red flag SNOOP(4)E features.*** In general, a secondary headache can be diagnosed if the headache is new and occurs in close temporal relation to another disorder that is known to cause headache. It can also be diagnosed when a pre-existing headache disorder significantly worsens in close temporal relation to a causative disorder in which case both the primary and secondary headache diagnoses should be given. ICHD-3 diagnostic criteria are below.

General diagnostic criteria for secondary headaches:

☑ Any headache not better accounted for by another ICHD-3 diagnosis and meeting the below criteria

☑ Another disorder scientifically documented to be able to cause headache has been diagnosed. Evidence of causation demonstrated by at least two of the following:

- ○ Headache has developed in temporal relation to the onset of the presumed causative disorder.
- ○ Either or both of the following: headache has significantly worsened in parallel with worsening of the presumed causative disorder or headache has significantly improved in parallel with improvement of the presumed causative disorder.
- ○ Headache has characteristics typical for the causative disorder.
- ○ Other evidence exists of causation.

SNOOP(4)E

S ystemic symptoms, illness, or condition (e.g., fever, chills, myalgias, night sweats, weight loss or gain, cancer, infection, giant cell arteritis, pregnancy or postpartum, or an immunocompromised state – including HIV)

N eurologic symptoms or abnormal signs (e.g., confusion, impaired alertness or consciousness, changes in behavior or personality, diplopia, pulsatile tinnitus, focal neurologic symptoms or signs, meningismus, or seizures ptosis, proptosis, pain with eye movements)

O nset (e.g., abrupt or "thunderclap" where pain reaches maximal intensity immediately or within minutes after onset; first ever, severe, or "worst headache of life")

O lder onset (age ≥ 50 years)

P rogression or change pattern (e.g., in attack frequency, severity, or clinical features)

P recipitated by Valsalva (e.g., coughing or bearing down)

P ostural aggravation

P apilledema

E xertion

Headache Diary Suggestions

There are a variety of options for headache diaries available. Click the link or visit the VA website below to access the VA/DoD CPG Management Heachache Diary (7-day and 3-month.)

For information on treatment options, refer to the 2020 VA/DoD Clinical Practice Guideline for the Primary Care Management of Headache - Provider Summary at https://www.healthquality.va.gov/guidelines/pain/headache