HALEON

LACK OF SLEEP
STRESS INDUCED
PARALYSING
CLUSTER
CAN'T CONCENTRATE
HITS HARD
LASTS HOURS TO DAYS
DOUBLE VISION
NAUSEATING
MIGRAINE
CAN'T FUNCTION
TENSION
INSUFFERABLE
BLINDING
CAN'T SEE PROPERLY
FEELING FAINT
NOT MYSELF ANYMORE
PHYSICALLY SICK

Patient **case study.**

Headache

#ListenToPain

Brought to you by the makers of

Start here

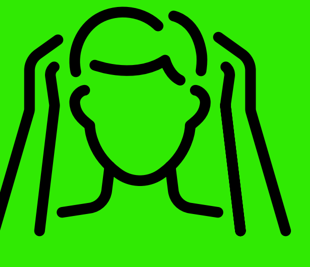
Presentation

Gregory

45 years.

Gregory is an executive working in a middle management position at a leading financial organisation.

He complains of frequent headaches, often towards the end of the working day.



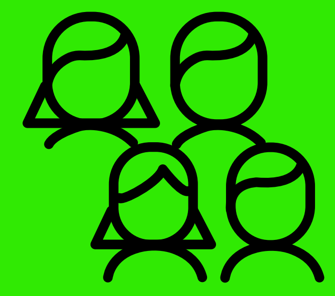
Presentation

He is, however, now very worried about these frequent headaches that he had been neglecting all this while.[1]

He undergoes regular health screenings.

3 years ago he was diagnosed with moderate hypertension and takes β-blocker 50mg once a day, regularly.

He has to continue working in the evenings in spite of a headache.[1] This substantially impacts his work performance and QoL.[1]



QoL, quality of life.

1. Simic S, et al. *Int J Environ Res Public Health* 2020;17(18):6918.a.

History

Detailed history:

- Headaches mostly in the evenings since > 3 months, almost 4 times a week, lasting for 3 to 4 hours.
- Pain appears as a band extending bilaterally back from the forehead across the sides of the head to the occiput.
- Sometimes, headache extends to the posterior neck muscles.
- Varies from mild-to-moderate-intensity pressure-pain.
- No associated nausea or vomiting.
- Feels eye strain but no visual disturbances.

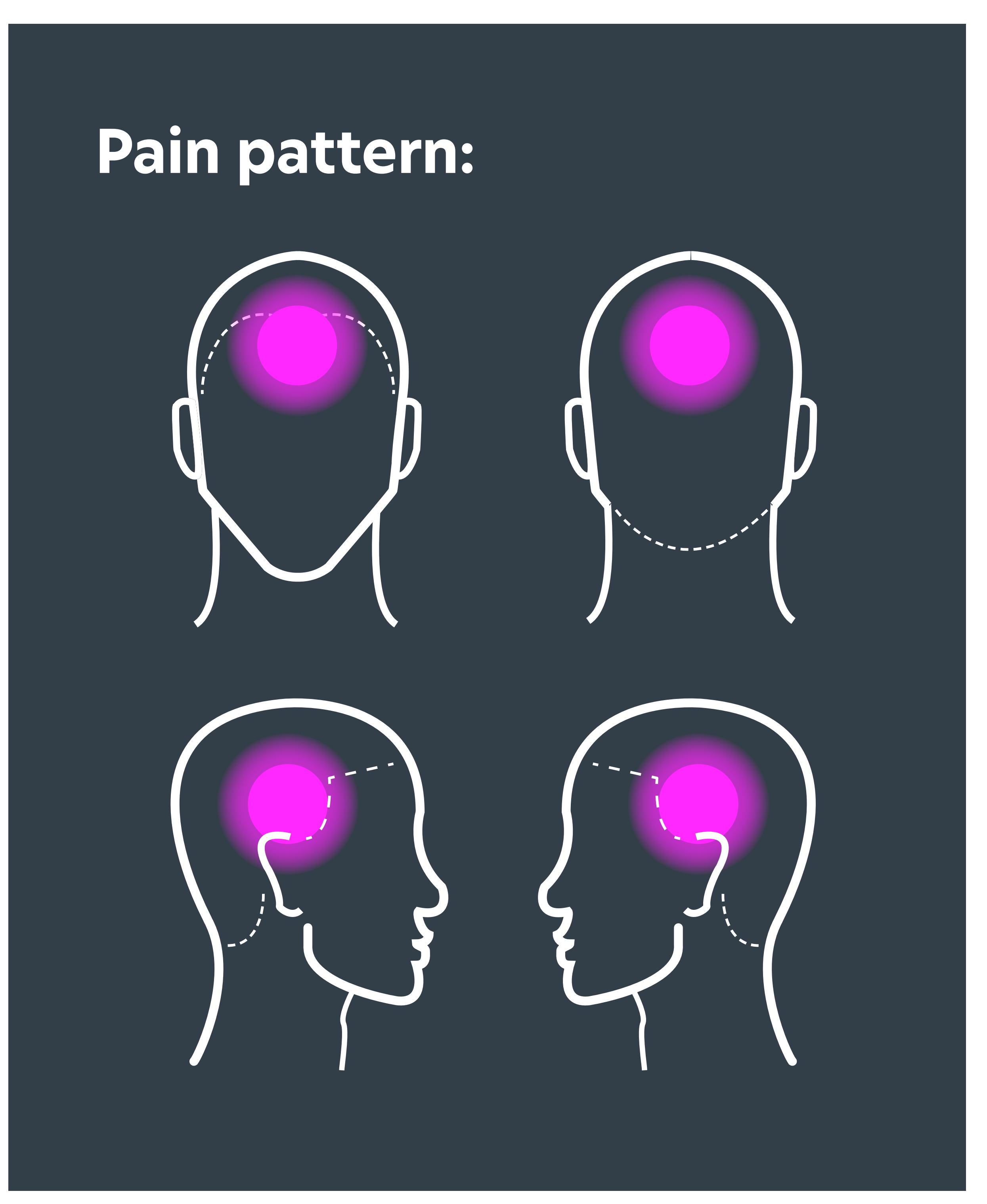
Aggravating and alleviating features:

- Continuous and long working hours seem to trigger the headaches.

Past history:

- Hypertension for 3 years, takes atenolol 50mg once a day, regularly, BP is well maintained since then.
- No history of diabetes or any other chronic illness.
- No significant family history.
- Has regular health check ups.

Pain pattern:



BP, blood pressure.

Clinical examination.

- General appearance: **Good.**
- **Pericranial muscle tenderness present.**
- **BP: 126/80mmHg.**
- PR: 66bpm.
- Temperature: 37°C.
- BMI: 22.1kg/m^2.
- Systemic and physical examination did not reveal any significant findings.

BMI, body mass index; BP, blood pressure; PR, pulse rate.

Approach to evaluation and management.

01

What type of headache does Gregory have?

02

How can he best manage his headaches which are impacting his quality of life?

03

What do guidelines say?

04

What is the clinical evidence?

05

Which is the most suitable medicine for Gregory?

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Clinical examination

HALEON

What type of headache does Gregory have?

Click an option to select your answer.

MIGRAINE

TENSION HEADACHE

TRIGEMINAL AUTOMATIC CEPHALALGIAS

SECONDARY HEADACHE

OTHER HEADACHE DISORDER

HALEON

Clinical examination

What type of headache does Gregory have?

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SECONDARY HEADACHE

× OTHER HEADACHE DISORDER

#ListenToPain

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What type of headache does Gregory have?

Click an option to select your answer.

MIGRAINE

TENSION HEADACHE

TRIGEMINAL AUTOMATIC CEPHALALGIAS

SECONDARY HEADACHE

OTHER HEADACHE DISORDER

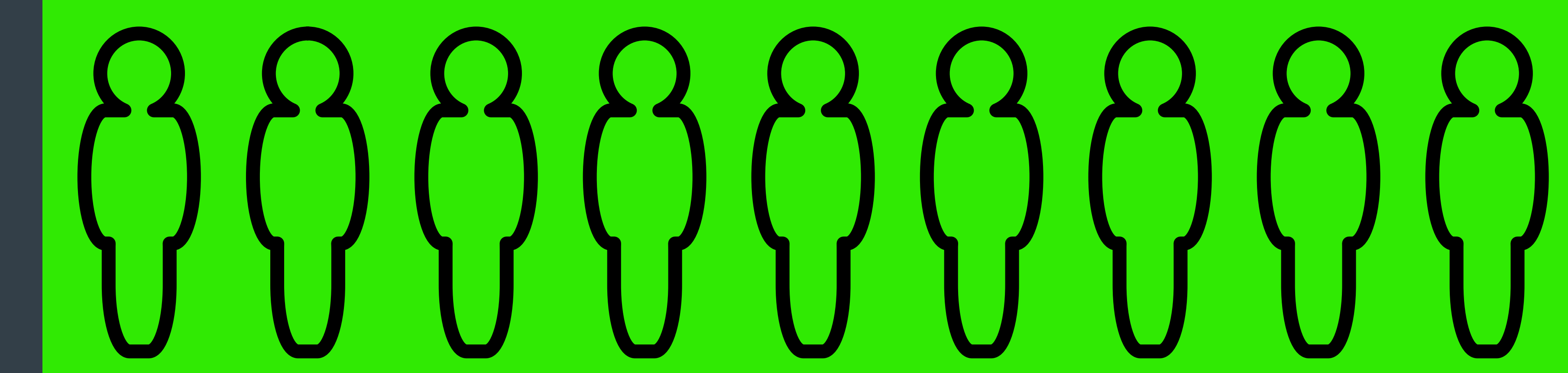
HALEON

Differential diagnosis

Based on history and physcial examination ruling out any other cause of headache including hypertension (as his BP is well controlled),[1]

Gregory is most likely suffering from primary headache.

More than 90% of patients who present to their primary care provider for evaluation of headaches have a primary headache disorder.[1,2]



International Classification of Headache Disorders

BP, blood pressure.

1. Headache Classification Committee of the International Headache Society. *Cephalatgia* 2018;38(1):1–211. 2. Rizzoli P, Mullally W. *Am J Med* 2018;131(1):17–24.

International Classification of Headache Disorders.[1,2]

×

Part 1

The primary headaches

1. Migraine
2. Tension-type headache
3. Trigeminal autonomic cephalgia
4. Other primary headache disorders

Part 2

The secondary headaches

Headache (or facial pain) attributed to:

5. Trauma or injury to the head and/or neck
6. Cranial or cervical vascular disease
7. Nonvascular intracranial disorder
8. A substance or its withdrawal
9. Infection
10. Disorder of homeostasis
11. Disorder of the cranium, neck, eyes, ears, nose, sinuses, teeth, mouth, or other facial or cervical structure
12. Psychiatric disorder

Part 3

Painful cranial neuropathies, other facial pains, and other headaches

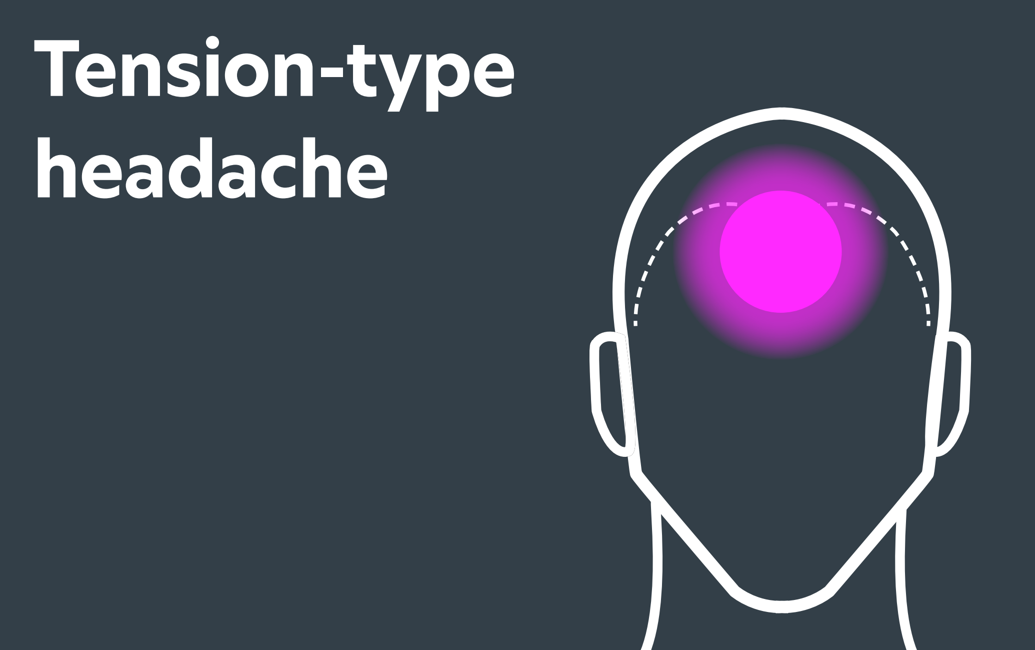
13. Painful cranial neuropathies and other facial pain
14. Other headache disorders

Differential diagnosis

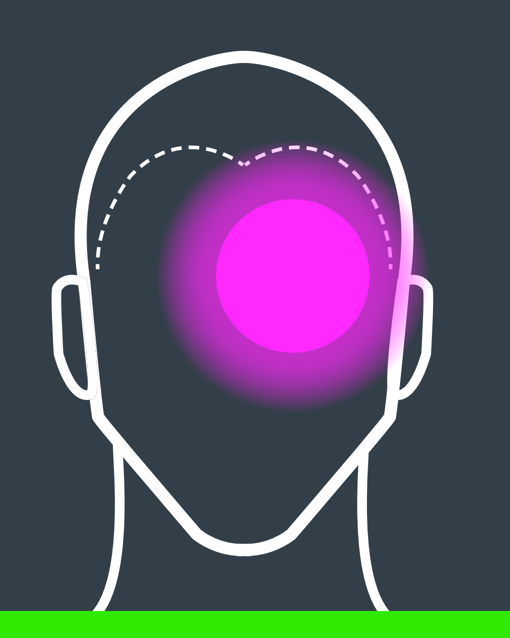
What type of primary headache does Gregory have?

Migraine

Tension-type headache

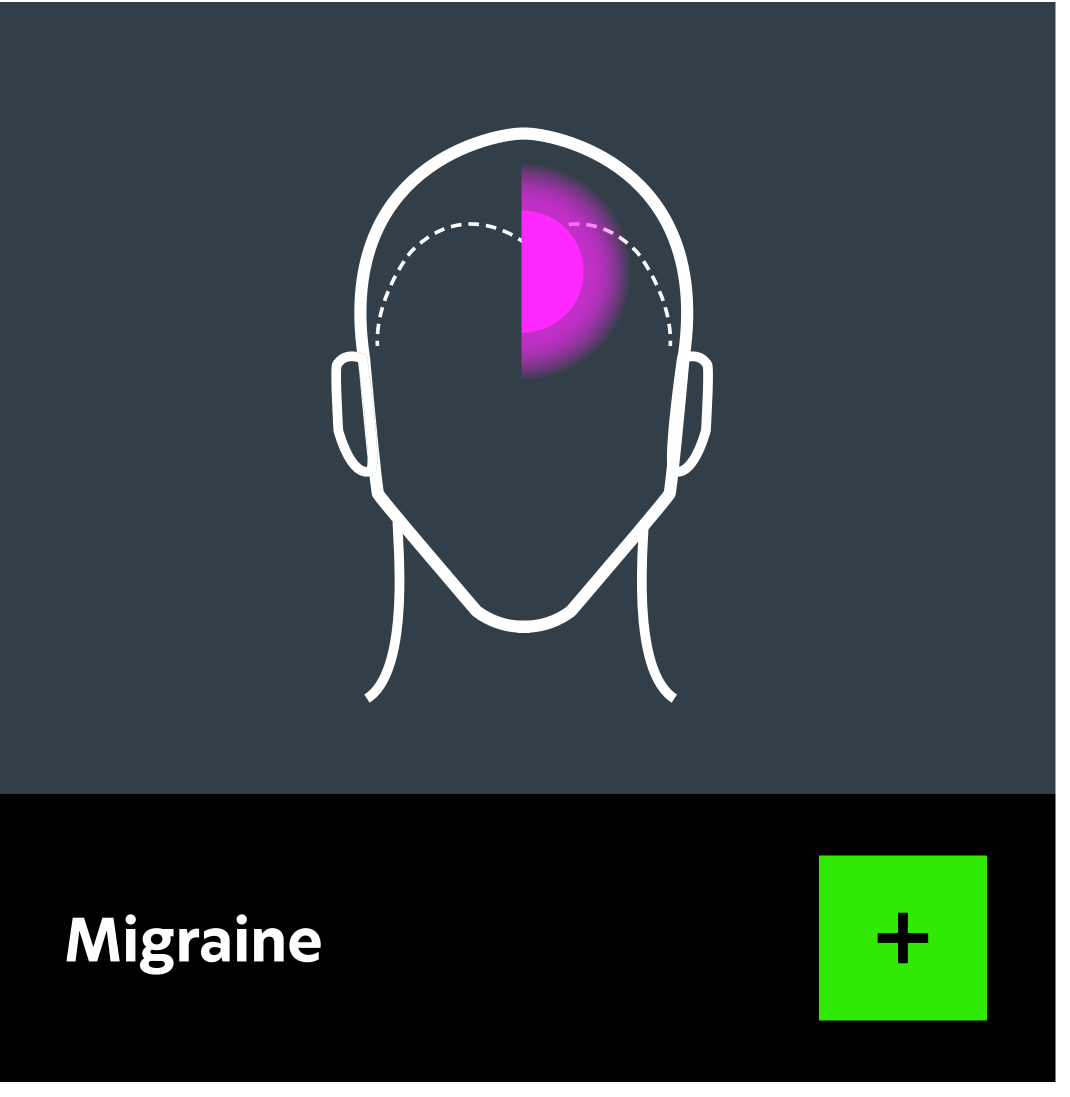


Trigeminal autonomic cephalalgias

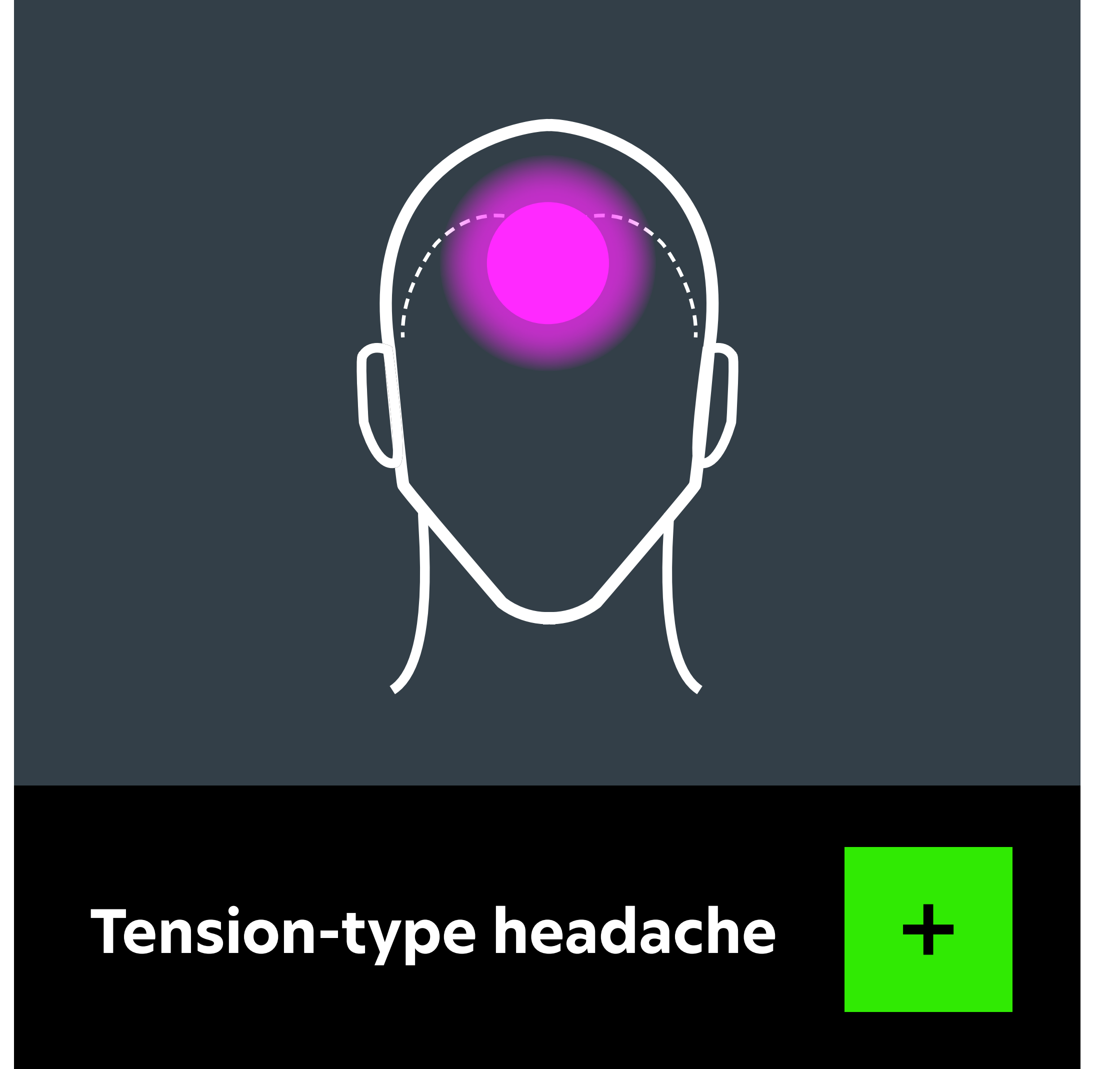


How do we differentiate?

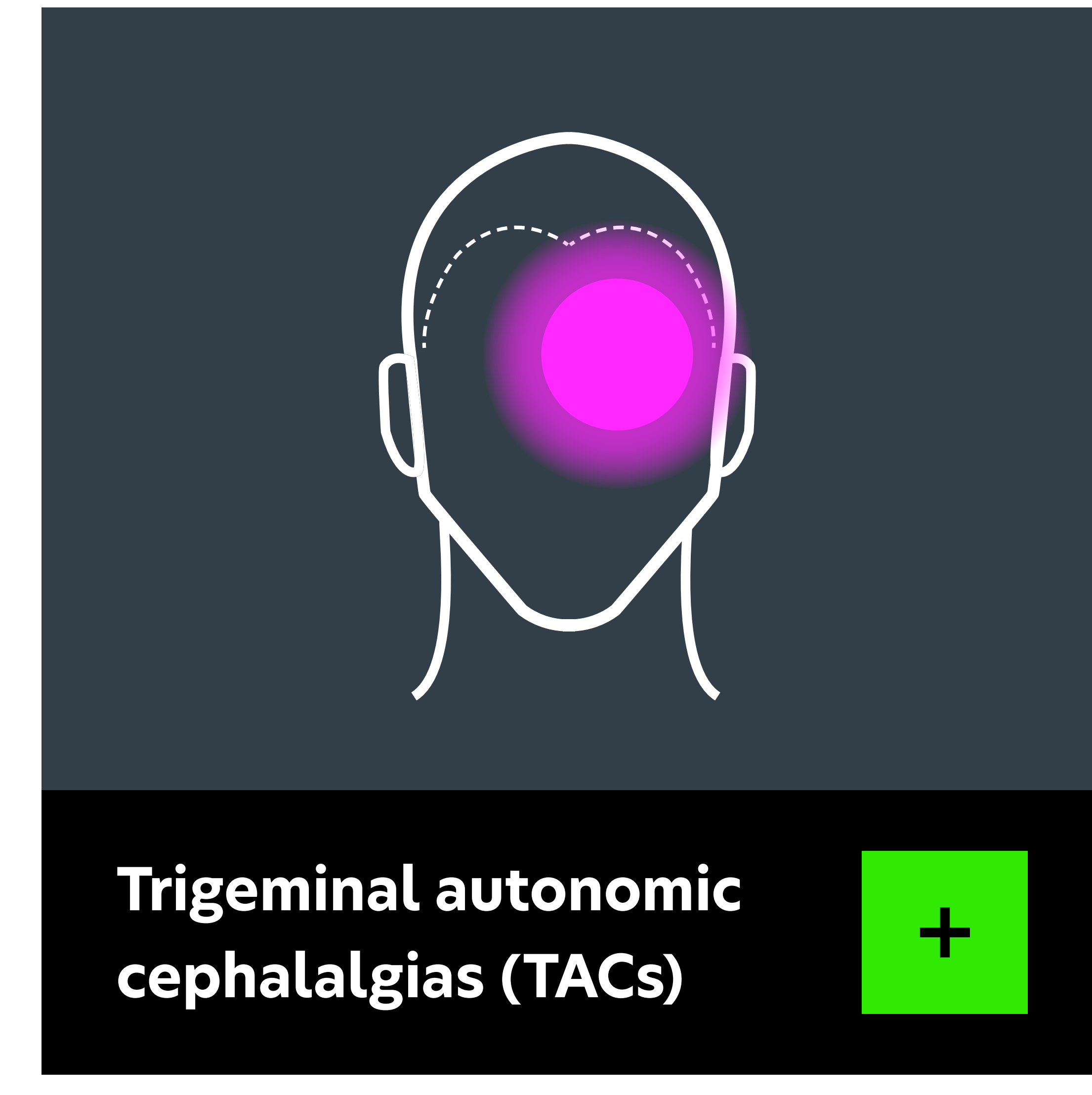
What is the guidelines-based differential diagnosis of primary headaches?[1-3]



Migraine +



Tension-type headache +



Trigeminal autonomic cephalalgias (TACs) +

1. Headache Classification Committee of the International Headache Society. *Cephalalgia* 2018;38(1):1–211. 2. Rizzoli P, Mullally W. *Am J Med* 2018;131(1):17–24. 3. Becker W, *et al. Can Fam Physician* 2015;61(8):670–679.

Differential diagnosis

What is the guidelines-based differential diagnosis of primary headaches?[1-3]

Migraine

- **A. At least five attacks[1] fulfilling criteria B-D**
- **B. Headache attacks lasting 4-72 hours (when untreated or unsuccessfully treated).[2,3]**
- **C. Headache has at least two of the following four characteristics:**
  1. Unilateral location
  2. Pulsating quality
  3. Moderate or severe pain intensity
  4. Aggravation by, or causing avoidance of, routine physical activity (e.g., walking or climbing stairs)
- **D. During headache at least one of the following:**
  1. Nausea and/or vomiting
  2. Photophobia and phonophobia

1. Headache Classification Committee of the International Headache Society. *Cephalalgla* 2018;38(1):1-211. 2. Rizzoli P, Mullally W. *Am J Med* 2018;131(1):17-24. 3. Becker W, *et al. Can Fam Physician* 2015;61(8):670-679.

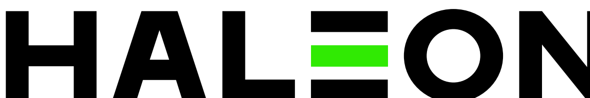
Differential diagnosis

What is the guidelines-based differential diagnosis of primary headaches?[1-3]

Tension-type headache

- **A. At least 10 episodes of headache occurring on <1 day/month on average (<12 days/year) and fulfilling criteria B-D**
- **B. Lasting from 30 minutes to seven days**
- **C. At least two of the following four characteristics:**
  1. Bilateral location
  2. Pressing or tightening (non-pulsating) quality
  3. Mild or moderate intensity
  4. Not aggravated by routine physical activity such as walking or climbing stairs
- **D. Both of the following:**
  1. No nausea or vomiting
  2. No more than one of photophobia or phonophobia

1. Headache Classification Committee of the International Headache Society. *Cephalalgia* 2018;38(1):1–211. 2. Rizzoli P, Mullally W. *Am J Med* 2018;131(1):17–24. 3. Becker W, *et al. Can Fam Physician* 2015;61(8):670–679.



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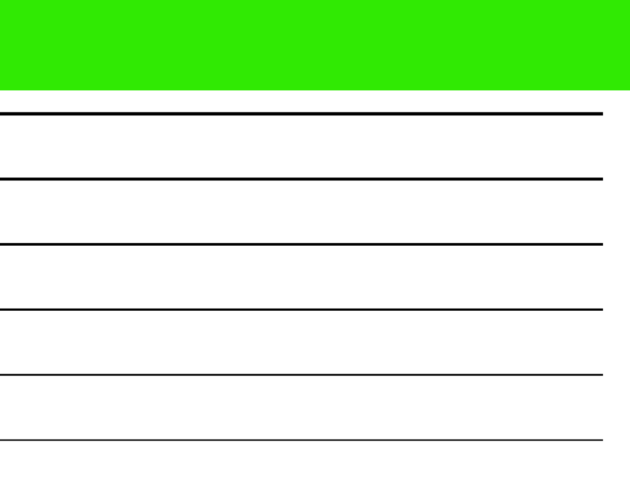


Trigeminal autonomic cephalalgias (TACs)

A. At least five attacks[1] fulfilling criteria B-D

B. Severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15-180 minutes (when untreated)[2,3]

C. Either or both of the following:

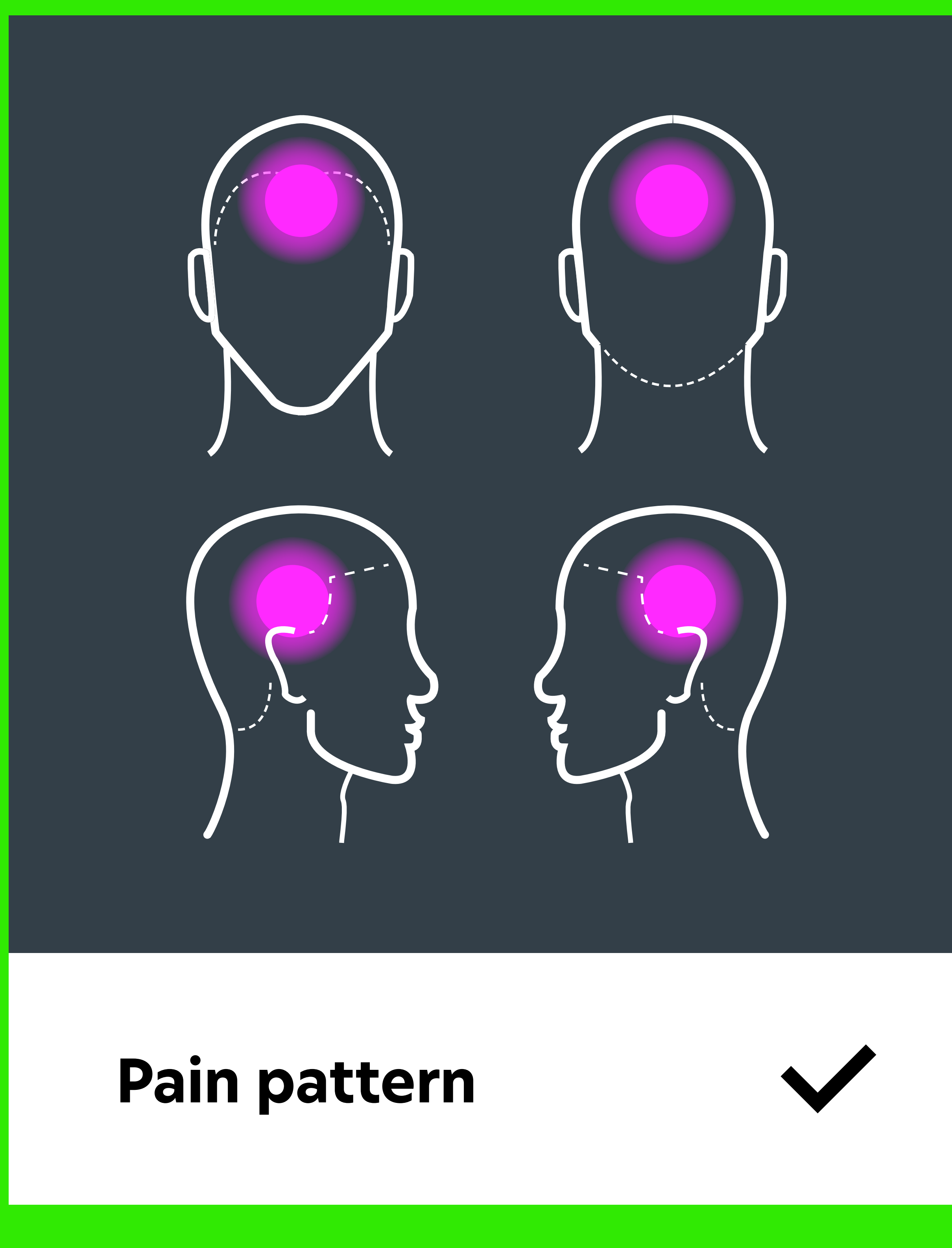
1. At least one of the following symptoms or signs, ipsilateral to the headache:
   - a) Conjunctival injection and/or lacrimation
   - b) Nasal congestion and/or rhinorrhoea
   - c) Eyelid oedema
   - d) Forehead and facial sweating
   - e) Miosis and/or ptosis
2. A sense of restlessness or agitation

D. Occurring with a frequency between one every other day and eight per day[2]

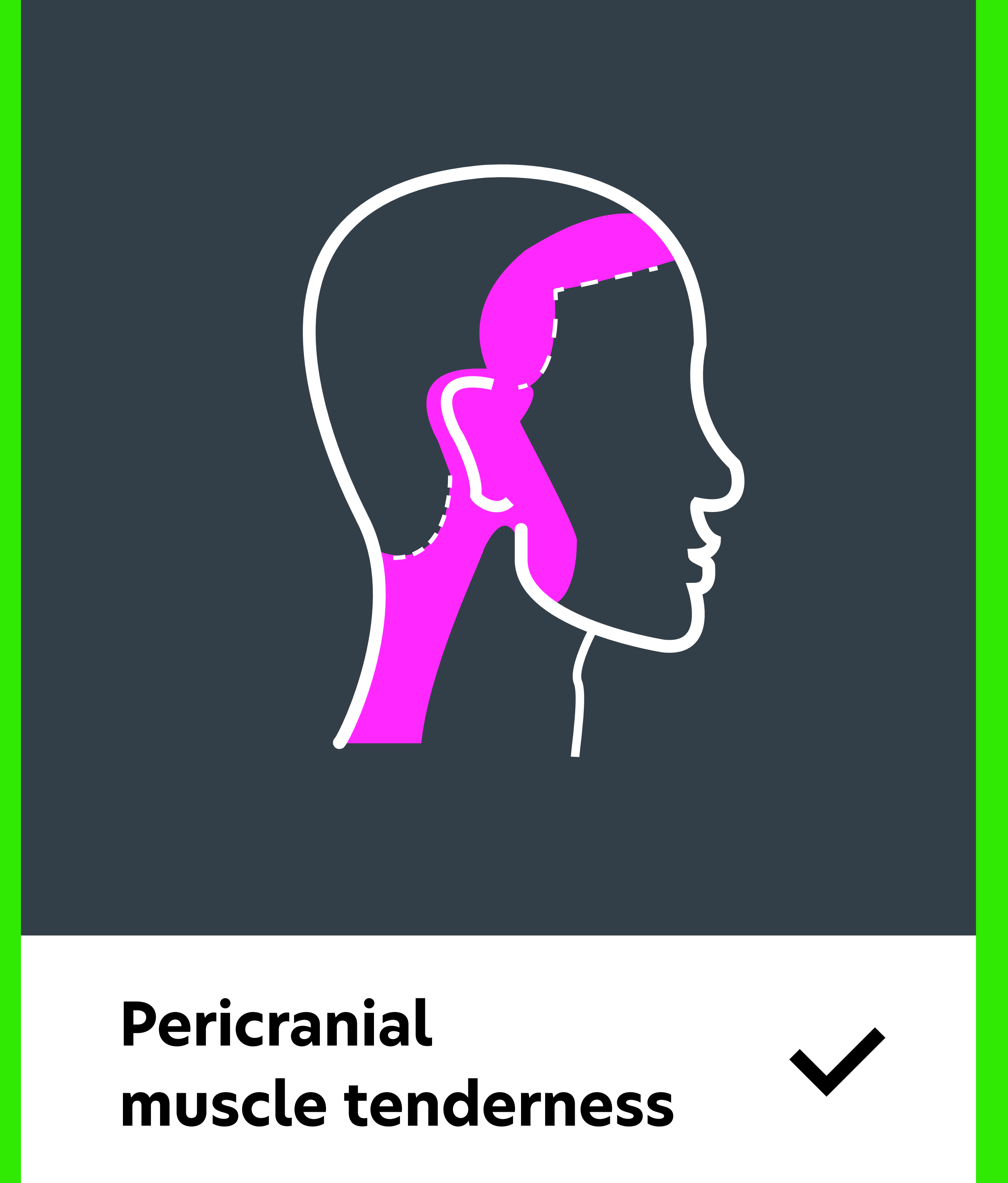
1. Headache Classification Committee of the International Headache Society. *Cephalalgia* 2018;38(1):1–211. 2. Rizzoli P, Mullally W. *Am J Med* 2018;131(1):17–24. 3. Becker W, *et al. Can Fam Physician* 2015;61(8):670–679.

Differential diagnosis

What is the diagnosis?



Pain pattern ✓



Pericranial muscle tenderness ✓

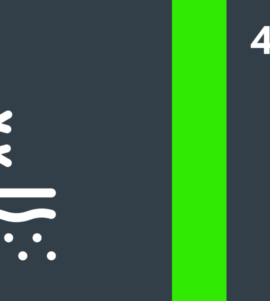
Therefore, Gregory has a tension-type headache

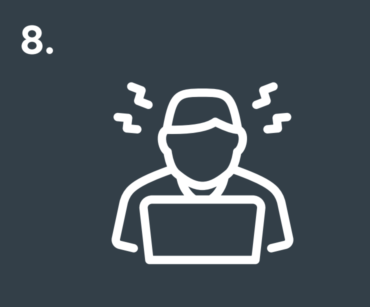
- It is a dull, bilateral, mild-to moderate-intensity pressure-pain.[1]
- Pericranial muscle tenderness is an important physical finding in the diagnosis of tension-type headache.[1]
- No nausea and vomiting.

1. Rizzoli P, Mullally W. *Am J Med* 2018;131(1):17–24.

Treatment plan

What **lifestyle modifications** should be suggested to Gregory?





Self-management interventions for tension-type headache are very effective in reducing pain intensity, mood and headache-related disability.[1]

1. Eat nutritious food on a regular schedule
2. Avoid excess caffeine
3. Ease muscle tension. Massage, apply heat or ice
4. Exercise regularly
5. Quit smoking
6. Relax. Try deep breathing exercises
7. Get enough sleep
8. Keep stress under control

1. Probyn K, *et al.* *BMJ Open* 2017;7(8):e016670. 2. Mayo Clinic. Tension-type headaches: Self-care measures for relief. Available at: www.mayoclinic.org/diseases-conditions/tension-headache/in-depth/headaches/art-20047631 (last accessed May 2021).

Treatment plan

What are the pharmacological options for TTH?

Tension-type headache is often managed with over-the-counter analgesics.[1-3]

Paracetamol (or APAP)

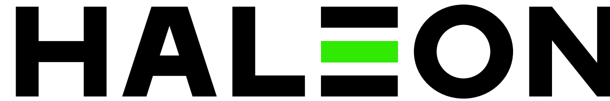
Ibuprofen

Acetylsalicylic acid

All of the above in combination with caffeine

APAP, n-acetyl-para-aminophenol; TTH, tension-type headache.

1. Derry C, *et al. Cochrane Database Syst Rev* 2012;(3):CD009281. 2. Ali Z, *et al. Curr Med Res Opin* 2007;23:841. 3. Zhang W. *Drug Saf* 2001;24:1127–1142.



Treatment plan

What are the pharmacological options for TTH?

Monotherapy in TTH.

For acute treatment of tension-type headaches, most guidelines recommend:

- **Paracetamol (500-1000mg); level I or grade A.**
- **Ibuprofen (200-800mg); level I or grade A.**

According to clinical guidelines, the choice of therapy should be based on patient risk profile.

Paracetamol is preferred in:

- Elderly.
- GI risk.
- Kidney disease.
- Children.
- CVD conditions like hypertension & diabetes.

Ibuprofen is the suitable choice amongst OTC NSAIDs for:

- Children under 14 years of age.
- Patients with GI risk.

★★★

Based on robust evidence
15 guidelines &
6 systemic reviews.[1–23]

International Headache Society
The European Federation of Neurological Societies
The American Headache Society
Canadian Headache Society

Primary efficacy parameter assessment for TTH is **"pain free after 2 hours"**

CVD, cardiovascular disease; GI, gastrointestinal; NSAID, non-steroidal anti-inflammatory drug; OTC, over-the-counter; TTH, tension-type headache.

View references ›

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2. Marmura M, *et al. Headache* 2015;55(1)3–20.

3. Oskoui M, *et al. Neurology* 2019;93(11):487–499.

4. National Institute for Health and Care Excellence (NICE). Headaches in over 12s: diagnosis and management. Clinical guideline CG150. Available at: www.nice.org.uk/guidance/cg150 (last accessed May 2021).

5. British Association for the Study of Headache. National headache management system for adults 2019. Available at: www.headache.org.uk/wp-content/uploads/2023/02/bash-guideline-2019.pdf (last accessed May 2021).

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9. China Knowledge Network. Guidelines for prevention and treatment of migraine in China. Available at: www.kns.cnki.net/KCMS/detail/detail.aspx?dbcode=CJFQ&dbname=CJFDLAST2016&filenae=ZTYZ201610003&v=MzA1MjFyQ1VSTE9mWXVkdkZ5am1VNzNQUHpuU2RMRzRIOWZOcjQRlo0UjhlWDFMdXhZUzdEaDFUM3FUcldNMUY= (last accessed May 2021).

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16. Bordini C, *et al. Arq Neuropsiquiatr* 2016;74(3):262–271.

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21. Cameron C, *et al. Headache* 2015;55(4):221–235.

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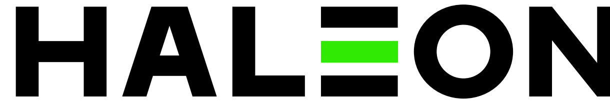


What are the pharmacological options for TTH?

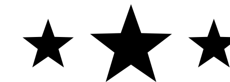
Combination therapy in TTH.

Compared to monotherapy, combinations of the following showed significantly improved efficacy with favourable tolerability in the vast majority of patients with TTH except for patients with CVD:[24]

- **Paracetamol + caffeine.**
- **Ibuprofen + caffeine.**

The German and Italian guidelines recommend:

- **Paracetamol + caffeine as first-line or Level I.**
- **Ibuprofen + caffeine is recommended as Level II by Italian (SISC) guideline only.**



Based on robust evidence 15 guidelines & 6 systemic reviews.[1–23]

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Primary efficacy parameter assessment for TTH is **"pain free after 2 hours"**

CVD, cardiovascular disease; SISC, Società Italiana per lo Studio delle Cefalee; TTH, tension-type headache.

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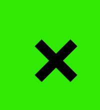

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HALEON

Treatment plan

What is the most suitable medicine for Gregory?

Gregory's risk profile includes:
Existing comorbidities - CVD (HYPERTENSION)

Click an option to select your answer.

PARACETAMOL /APAP

PARACETAMOL /APAP + CAFFEINE

IBUPROFEN

IBUPROFEN + CAFFEINE

APAP, n-acetyl-para-aminophenol; CVD, cardiovascular disease.

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HALEON

Treatment plan

What is the most suitable medicine for Gregory?

Gregory's risk profile includes:
Existing comorbidities - CVD (HYPERTENSION)

Click an option to select your answer.

PARACETAMOL /APAP

PARACETAMOL /APAP + CAFFEINE

IBUPROFEN

× **IBUPROFEN + CAFFEINE**

APAP, n-acetyl-para-aminophenol; CVD, cardiovascular disease.

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APAP, n-acetyl-para-aminophenol; CVD, cardiovascular disease.

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Follow-up

What should Gregory's **follow-up** management be?

Click an option to select your answer.

RECOGNISING TRIGGERS

LIFESTYLE MODIFICATIONS

ALTERNATE THERAPIES

ALL OF THE ABOVE

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Follow-up

What should Gregory's follow-up management be?

Click an option to select your answer.

× RECOGNISING TRIGGERS

LIFESTYLE MODIFICATIONS

ALTERNATE THERAPIES

ALL OF THE ABOVE

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RECOGNISING TRIGGERS

× LIFESTYLE MODIFICATIONS

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ALL OF THE ABOVE

HALEON

Follow-up

RECOGNISING TRIGGERS

LIFESTYLE MODIFICATIONS

× ALTERNATE THERAPIES

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What should Gregory's follow-up management be?

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Follow-up

What should Gregory's follow-up management be?

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- RECOGNISING TRIGGERS
- LIFESTYLE MODIFICATIONS
- ALTERNATE THERAPIES
- ALL OF THE ABOVE

Gregory's follow-up management.

Treatment goals for patients with TTH should not only include effective analgesic agents, **but also discovering and ameliorating any circumstances that may be triggering the headaches or causing the patient concern.**[1]

Alternate therapies

Consider offering non-medication treatments like biofeedback, relaxation training, self-hypnosis, and cognitive therapy, and traditional physical therapy exercises, using ice packs, massage, and "passive mobilisation" of the cervical facets.[1]

Lifestyle modifications

Seek consistency in lifestyle behaviours and dietary habits, such as change of food consumption pattern and alternative food choices, and cessation of smoking etc.[1]

Recognising triggers

There is evidence of an association between TTH and diet. Missing meals, smoking, spicy food, foods rich in MSG, coffee and chocolate may be triggers for TTH in South Asian populations.[2]

MSG, monosodium glutamate; TTH: tension-type headache.

1. Miliea P, Brodie J. *Am Fam Physician* 2002;66(5):797–804. 2. Tai M, *et al. J Pain Res* 2018;11:1255–1261.

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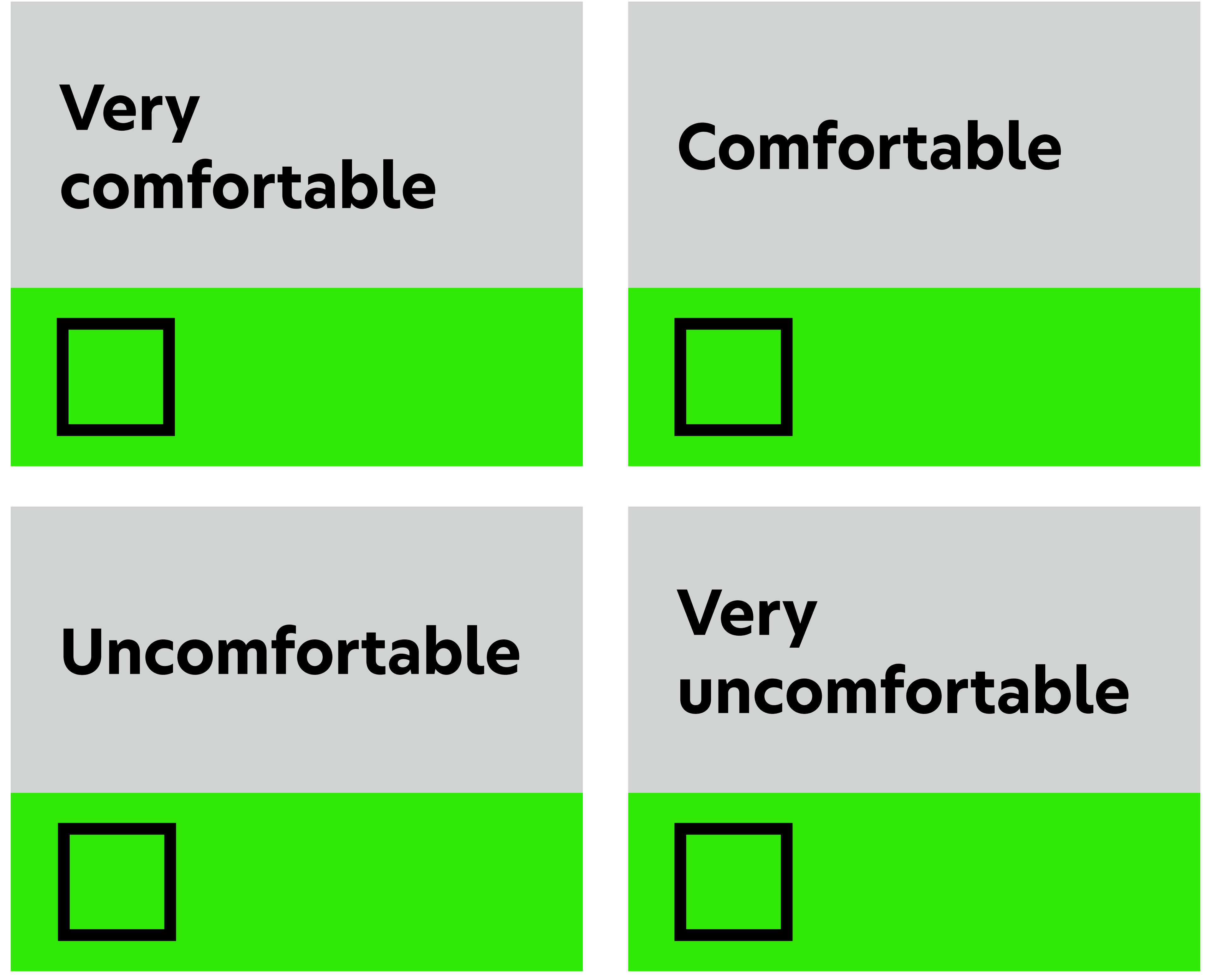
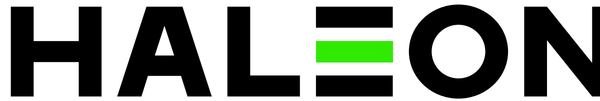
Based on this case study, how comfortable are you in making recommendations to patients like Gregory?

Click an option to select your answer.





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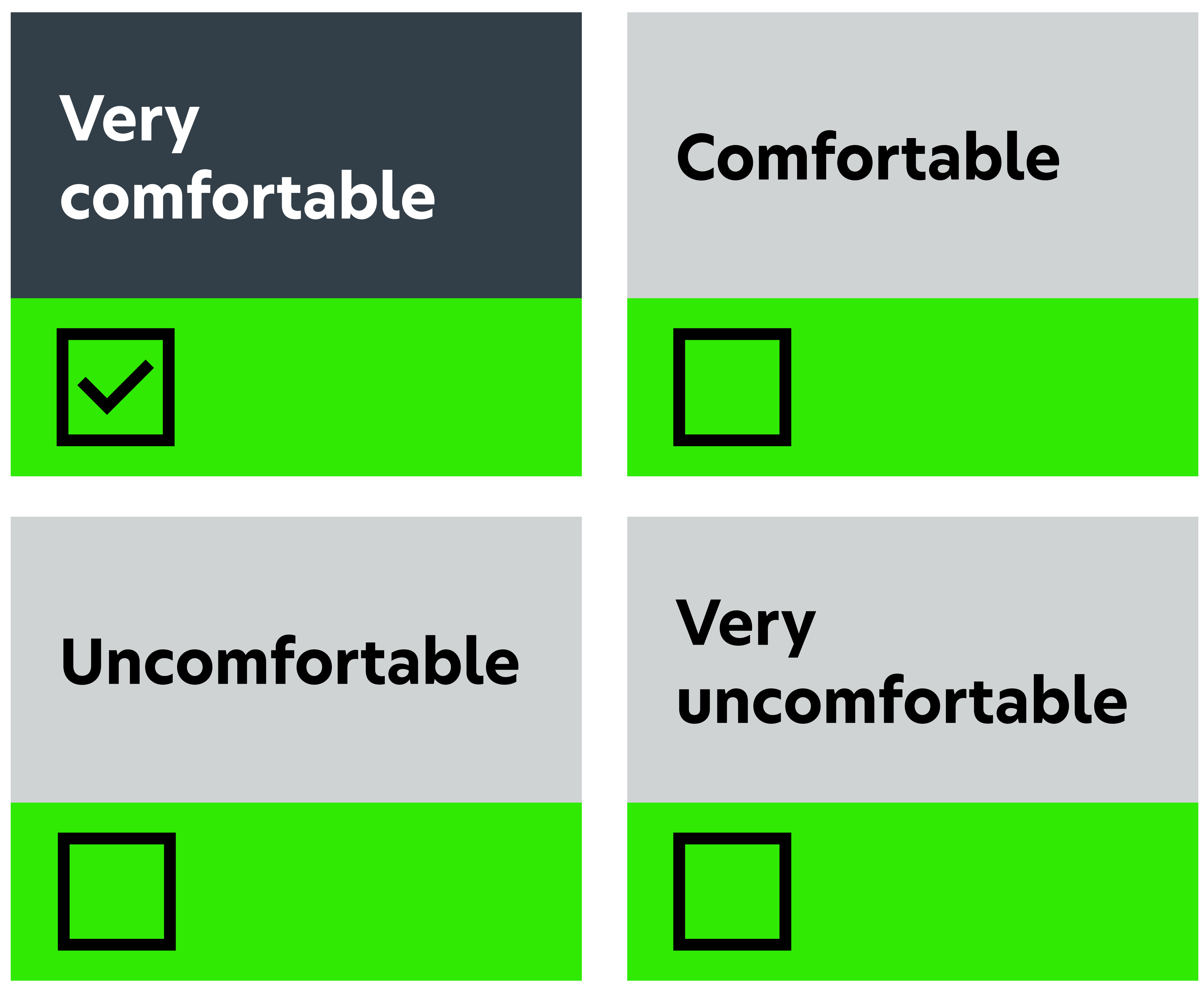

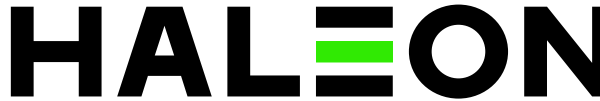

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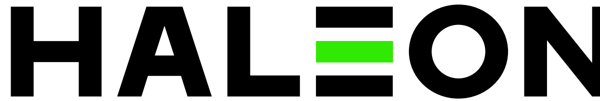

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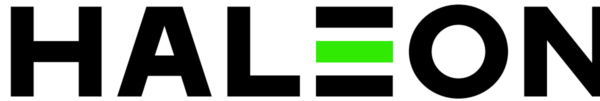

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