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REVIEW ARTICLE

Not All Severe Primary Headaches are Migraines – Tension Type Headaches are Far More Common Yet often Labelled as Migraines

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Abstract

Introduction: This paper reinforces the concept that headaches reside on a continuum with migraine type headache at one end of the spectrum and Tension Type Headache (TTHs) at the other with what used to be referred to as tension/vascular headaches, along that continuum.

Background information: This brief overview of headaches is based upon almost half a century of clinical neurological experience by the author, rather than an in depth analysis of definitions and is also dependent upon impressions of patient responses to treatment.

Results: Based upon clinical experience, one of the most common complaints that present to the neurologist is that of chronic headache, or headache in general, and so long as the headache is significantly intrusive it is referred to the consultant as a case of migraine even if the evidence favours an alternative headache type such as TTH.

Discussion: This paper confirms the concept, demonstrated in previous studies, that there is a continuum spectrum of headache types, with patients moving along that continuum with changing presentations at various times during a long history of headaches.

Keywords

Migraine, Tension type headaches, Continuum spectrum, Headache classification

Introduction

Many colleagues refer to all bad headaches as migraine which seems inappropriate but is common practice. The International Headache Society (IHS) defines chronic migraine as the patient experiencing headaches on at least 15 days per month for at least 3 months of which at least 8 are of migraine quality [1]. The IHS lists primary headaches as: Migraines; Tension Type Headaches (TTHs); Trigeminal Autonomic Cephalalgias (TACs); and other primary headache disorders [1].

In concert with this definition [1], if the patient has headaches every day per month, which is not uncommon [2], and 8 of these conform to the definition of migraine headache, namely 8 of 30+ headache days could be labeled as migraines, and the rest adhere to the common understanding of TTHs, the patient is still labelled as a chronic migraineur despite the predominant headache being TTHs.

Previous research has demonstrated that those with chronic daily headache morph between different headache types and those who had episodic migraines, at the onset of their headache history, often present with chronic TTHs, up to 2 decades later [2]. This paper reinforces the concept that headaches reside on a continuum [3] with migraine type headache at one end of the spectrum and TTHs at the other with what used to be referred to as tension/vascular headaches, along the continuum [3], to accommodate those headache types that fail to adequately accommodate either TTH definitions or those relevant to migraine, presumably loosely

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included as those identified in the IHS primary headache type as “other primary headache disorders” [1], as the term tension/vascular headache is no longer in vogue, due to advanced understanding of the pathophysiology of headaches [4].

Background Information

This brief overview of headaches is based upon the almost half a century clinical neurological experience of the author, rather than an in depth analysis of definitions and is also dependent upon impressions of patient responses to treatment. It represents a clinical impressions quality rather than quantity report which challenges the current opinions, definitions and dogma, relevant to the latest HIS classifications [1] as these reflect research approaches rather than clinical frontline practical patient applications of therapeutic management. Based on these impressions, patient responses and hypothesis of the continuum concept of headaches it proffers a clinical approach to the management of headaches in everyday clinical practice.

Results

Based upon clinical experience, one of the most common complaints that present to the neurologist is that of chronic headache, or headache in general, and so long as the headache is significantly intrusive it is referred to the consultant as a case of migraine [5,6]. The imperative is to firstly define the most common presenting type of headache, in each individual patient, and to manage the patient in accordance with that predominant headache type [5,6]. By far the most common headache type, to present to the neurologist, is that of TTH, rather than migraine, despite the referral being for the management of migraine. This raises serious concerns as it has direct influence upon headache management and also raises concerns for why this should be so.

Review of the literature reveals that, especially in the United States of America, insurance rebates for TTH may be either considerably lower than those relevant to migraine or there may be no remuneration at all for TTH [6-8]. This creates bias that results in under-representation of the true extent of TTH, which remains the most prevalent type of headache to attend a neurological practice [6-8].

The most common treatment of headache, within the experience of the author, is the use of tricyclic antidepressants (such as amitriptyline or imipramine or nortriptyline) the choice of which is determined by availability and the presence or absence of symptoms of sleep disturbance [5,6]. Poor sleep patterns favour amitriptyline and good sleep patterns, despite headaches favours the latter two [5,6]. In the experience of the author, these are far less effective when the diagnosis favours the migraine end of the continuum and it is also less effective when, the old terminology favoured "tension/vascular headache" predominates. Response to treatment is the vital imperative, especially when reaching a diagnosis that is at odds with the prevailing opinions of those within the IHS, but it has absolute relevance to the wellbeing of the patient when choosing the best treatment modality. Some authorities will argue that tricyclics are still a real option for the management of migraine [9,10] but this is at odds with personal experience of the author, when the diagnosis is unequivocally at the migraine end of the spectrum [5,6].

Discussion

The purpose behind this paper is to challenge the artificial differentiation of headaches into absolute categories regarding headache diagnoses, proffering an alternative approach of considering headaches to represent a continuum of headache types represented by a spectrum, ranging from TTHs at one end of the continuum and migraine at the other [3]. This concept is based on almost half a century of continuous clinical practice by the author. The idea that despite the patient experiencing migraine headaches on only a third of the days in which headaches occur and still to be labelled as being a migraineur, despite the predominant headache being TTH, is counterintuitive.

In the author’s experience, TTH are best managed using tricyclic antidepressants, as compared with the use of specific anti-migraine agents [3,5,6], thereby reinforcing the concept of a continuum, despite there being a body of opinion advocating tricyclic antidepressants for migraine management [9,10]. Previous research has demonstrated the changes experienced by headache sufferers who may initially present with one headache type, at one stage of their headache history, and a different headache type at a different stage of their illness [2]. This provides clear, and unequivocal, evidence of the potential for people with headaches to migrate along the hypothesised continuum spectrum of headaches [3]. This represents a demonstration of the importance of keeping an open mind, when managing headaches, as it reinforces the concept that treatment should be directed towards the predominant headache type, relevant at the time of presentation, rather than an artificial classification into absolute, and specific, diagnostic categories, as would appear within the IHS dogma [1].

One of the prevailing arguments is that the concept, that the most common headaches are migraines, may have its basis in pecuniary consideration that relates to medical rebates available for headache management by treating neurologists, specifically in the United States of America [7,8]. In the experience of the author, TTHs still remain the cornerstone of headache presentations and tricyclic antidepressants are the mainstay of patient care [3,5,6]. This paper confirms the concept, demonstrated in previous studies [2], that there is a continuum

spectrum of headache types with patients moving along that continuum with changing presentations at various times [2].

Conflict of Interest

There are no conflicts of interest to declare.

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