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Other Primary Headache Disorders

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Refractory Headache Diagnosis and Management

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Are you a member of the IHS?: Yes

Has the abstract been published or presented before?: No

Would you like to have your abstract considered for presentation within the Trainees Excellence Tournament on Saturday 7 September 2019. By ticking 'Yes', you confirm that you are aTrainee or Junior and would like to be considered. : No

Presentation Preference: Oral

Objective: The definition of refractory headache(RH),is still not clearly described.

Methods: I searched MEDLINE,ScienceDirect and used the latest IHS guideline and reported my personal experiences with more than 30,000headache patients.

Results: There are different causes that make a headache refractory.

1.First, misdiagnosed cases due to of different reasons:

A-When a physician cannot get an accurate history. One of the causes of misdiagnosis is medication overuse headache (MOH) which is sometimes ignored by physicians.

B-When a physician ignores the previous history of headache in the patient. For example in chronic migraine headache the history of episodic migraine with gradual accentuation is necessary but sometimes the patients give the history of their recent chronic headache and taking the history of their previous episodic headaches is very difficult and needs more attention.

C-When a physician does not consider the probability of secondary headaches including cervicogenic headaches,SIH,IIH without papilledema,oral,nasal or temporomandibular joint disorders.

2.Improper treatment: It is very important to titrate prescribed medications to the maximum tolerable dosage and wait for at least two months for propper response. Concurrent analgesic overuse is also common among RH subjects and might cause prophylactic treatment-ineffective,.

3.Presence of comorbidities: Psychiatric disorders, particularly in adolescent patients should be treated with high accuracy.

4.Drugs that a patient consumes for the other diseases could also be a reason for susceptibility to RH.

5.Ignoring other modalities of treatment: Nerve or ganglion blocks,neurostimulations and surgeries could be promising in the management of difficult to treat patients.

6.Real refractory cases are present but are not as numerous as physicians think.Chronic migraines, chronic clusters, other TACs, and different types of neuralgias might be refractory.

Conclusion: In RH cases with poor response to outpatient therapy, or unsuccessful outpatient detoxification for overuse of specific medications,or those with severe psychiatric comorbidities, inpatient management should be considered and should include controlling patient’s pain,discontinuing offending drugs in the case of MOH, medical or psychiatric consults and initiating the suitable prophylactic therapy.