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Mini Review

Types of Headaches and Causes

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Mini review

There are three main categories of headaches and they are classified as primary and secondary.

Primary headaches: Englobe the commonest types of headaches such as migraines, tension headaches, cervicogenic, cluster headaches, sinus related headaches and hormone related headaches.

Secondary headaches: Are more severe and usually of malignant cause.

Tertiary headaches: Are cranial neuralgias.

Primary headaches

A. Migraines: They are the result of abnormal electric signals within the brain and may come with or without auras (preceeding signs). Presentation-wise they tend to be unilateral, of frontotemporal distribution, may be described as pulsatile or throbbing, with an increasing intensity and can last from a few hours to a few days. Common associated symptoms are nausea, vomiting, photosensitivity and phonophobia. The underlying causes of migraines are unknown and are believed to be a mix of environmental and genetic factors. The associated triggers can be psychological, dietary and environmental [1].

B. Tension headaches: T.H are usually of a muscular origin, can be cured with over the counter analgesics. They tend to be of bilateral presentation and presenting band-like around the head, usually the frontal aspect of the head and no noted associated signs and symptoms (can vary from a person to another), mild to moderate intensity and are not aggravated by physical activity. Tension headaches are the most common type of primary headache [2].

C. Cluster headaches: C.H are a group of idiopathic headaches and are associated with trigeminal neuralgia however they can also be associated with genetics, tobacco and hypothalamus disorders but the exact cause is unknown. They usually present unilaterally (fronto-temporal) and peri-orbital pains. The increase in intensity tends to be quick and can be severe. They can last up to a few hours and commonly associated symptoms are usually linked to the trigeminal distribution (3 branches, and tend to affect the ophthalmic branch, V1, sensory), or even horner's like (ptosis, miosis, anhidrosis) or facial nerve. They tend to affect men in their late 20s though women and children can get them as well. They are rather rare.

D. Hormonal headaches: H.H are triggered by hormonal imbalances or changes within the body. They can be associated with low oestrogen concentration, usually at the beginning of the menstrual cycle or withdrawal of hormone therapy (Figure 1).

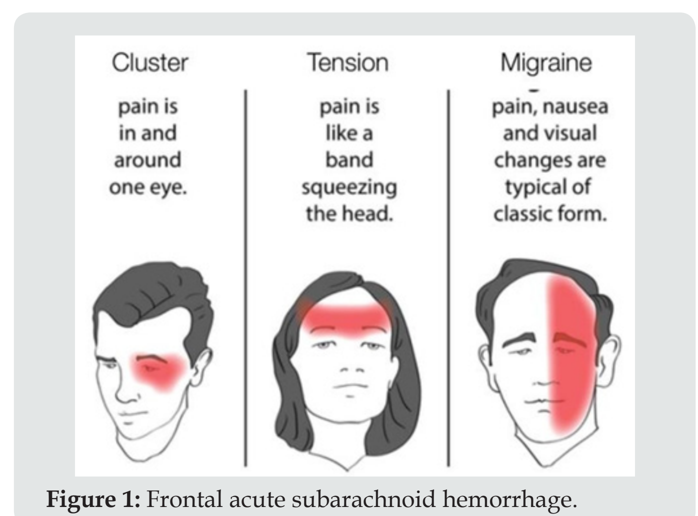

Figure 1: Frontal acute subarachnoid hemorrhage.

Secondary Headaches or cervicogenic Headaches

They considered «red flags» headaches and are usually linked to underlying pathologies such as haemorrhages (intracranial, subdural or other) giant cell arteritis, internal carotid dissection, aneurysm, meningitis, tumour and some GIT conditions.

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For example, sinus headaches can be considered secondary due to increased pressure or infection within the sinuses.

Other pathologies associated to secondary headaches are: IC haematoma (due to whiplash?), vascular disorders (stroke, haemorrhage, hypertension, arteriovenous malformation), non-vascular intra cranial disorders (CSF, ICP pressure issues), pulmonary (obstructive sleep apnea, hyperventilation), Neurologic (post-seizure, cranial neuralgia, brain abscess, hydrocephalus, herpes zooster, optic neuritis), substance withdrawal, infection (meningitis, encephalitis, HIV,..), disorders of homeostasis (hypoxia, eclampsia), cervicogenic, TMJ, psychiatric disorder, Renal (renal insufficiency, dialysis in the case of first use syndrome), Gynae (pregnancy, dysmenorrhea), iatrogenic, neoplastic causes.

They tend to be screened with the following rules:

a. Systemic symptoms presentation (constitutional or neoplastic)

b. Abnormal neurological symptoms

c. Insidious or new-onset, over 40 years old and rapid progression in intensity or sudden (thunderclap), in the AM presenting in the occipital area

d. High blood pressure

e. No previous headache history

Tertiary headaches

Cranial neuralgias such as trigeminal neuralgia (sensory 3 branches and motor mandibular), glossopharyngeal neuralgia, occipital neuralgia, herpes zooster in CSP/TSP, MS, constant pain caused by compression/irritation/distortion of cranial nerves or upper cervical roots by structural lesions.

References

1. Goodman (2017) Differential diagnosis for physical therapists. screening for referral Heick and Lazaro(Eds) . pp 528-531.
2. Fayyaz Ahmed (2012) Headache disorders: differentiating and managing the common subtypes. Br J Pain 6(3): 124-132.

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