CLINICAL VIGNETTE

Unusual Persistent Fixed Headache

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A previously healthy 65-year-old male presented with a persistent right temporal headache that he described as constant aching and throbbing except during sleep. He also had occasional nasal congestion and eye tearing especially when the headaches worsened. He tried aspirin, acetaminophen, and ibuprofen, which helped if he took enough. Triggers were stress and occasionally alcohol and exposure to cold weather or air conditioning. Eventually he was given a trial of indomethacin and within minutes the headache completely disappeared, establishing the diagnosis of hemicranias continua.

The patient reported an influenza vaccination two months prior, as one of his colleagues who also had a vaccination developed a "migraine headache" that lasted two months but eventually resolved. He had undergone extensive dental work but the dental pain eventually resolved. He also had a rear end auto accident and noted neck pain at that time which also resolved. He was evaluated with CT of the brain which was negative.

Past medical history was negative for migraine, diabetes, hypertension, liver or kidney disease, pulmonary GI or GU disease, anemia or cancer. He took no chronic medications. Family history was negative for headaches and migraine.

He is married and works as a physician. He drinks 4 oz. of wine per night. Physical examination revealed a healthy appearing white male, height 6 feet, weight 163lbs. HEENT: ENT clear. Scalp non tender. TMJ negative. Temporal arteries with good pulses and non-tender. Carotids clear without bruits. Cardiac rate and rhythm were regular with no murmur or gallop. Cranial nerves intact and motor function was normal bulk, tone and power. His coordination was station, gait, Romberg and intact. Sensory exam was intact to pinprick, light touch, vibration and proprioception. DTR: Symmetric at the biceps, brachioradialis, knee jerks and ankle jerks. Plantar responses downgoing. The patient's mental status, speech, language and memory were normal. CT and MRI of brain were normal.

Discussion

Hemicrania continua (HC) is a unilateral headache that is continuous in nature, is extremely rare with only a few hundred cases published in the literature.[1] It tends to have onset in the third decade of life. It is more common in women than men with an estimated ratio of 2:1. HC has an absolute responsiveness to indomethacin.[2-5] Most patients with hemicranias have unremitting pain in the anterior regions of the head but can include the occiput. The most common cranial autonomic features include lacrimation, nasal congestion, conjunctival injection, ptosis, miosis, and dripping sensation at the back of the throat. Superimposed jabs and jolts occur frequently. The diagnosis of HC is dependent upon the clinical features of the headache and the absolute response to indomethacin.[1,3,4]

Neuroimaging is suggested to rule out structural brain lesion. The posterior hypothalamus and dorsal rostral pons seem to play a role in the pathophysiology of HC. The differential diagnosis of primary HC includes secondary HC, chronic migraine, cluster headache and syndromes of short lasting unilateral neuralgiform headache attacks and short-lasting unilateral neuralgiform headache attacks with cranial autonomic symptoms. Chronic migraine when strictly unilateral and side-locked can be confused with HC. The trigeminal autonomic cephalalgias are a group of primary headache disorders characterized by unilateral trigeminal distribution pain that occurs in association with ipsilateral cranial autonomic features. Cluster headaches and HC are types if trigeminal autonomic cephalalgias that may be occasionally confused with HC.

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