



Headaches

DEFINITION	<p>Headaches are very common in women throughout the lifespan. There are several classifications of headaches, the 2 most common being tension and migraine (with or without aura). Tension headaches often result from normal everyday stress, muscle contractions in neck, back or scalp, etc. Migraine headaches are a more complicated neurological process often triggered by various environmental stressors such as food, odors, lack of sleep etc. Migraines in particular are often influenced by the hormonal changes that accompany the menstrual cycle. Women often report an increase in migraine frequency as menstruation approaches or during the first few days of menstruation. Combined hormonal contraception may be beneficial in that it decreases the normal peaks and troughs of progestin and estrogen that may trigger migraines. Some women, however, may find that combined hormonal contraception may trigger new onset of migraines, or worsen existing conditions. Management of these cases must be done on an individual basis. In addition, there is growing research to suggest that women who have a history of migraines accompanied by focal neurological symptoms (aura) who use combined hormonal contraception have a 2-4 fold increased risk of stroke. In women of all ages with a history of this type of migraine, use of combined hormonal contraception is explicitly contraindicated. WHO guidelines also indicate that in women >35 years old who experience migraine without aura after the initiation of combined hormonal contraception should cease using them. For that reason, all women who wish to begin combined hormonal contraception need to be carefully screened for any history of migraines. Life threatening headaches, caused by various factors, also need to be ruled out.</p>
SUBJECTIVE	<p>May include:</p> <ol style="list-style-type: none">1. History of intermittent tension headaches. Often mild-moderate in nature, described as being a “tight band” around the head, usually bilateral and do not meet the below criteria for migraine headaches.2. Migraine headaches. See Diagnostic Criteria below3. Severe headaches indicating potentially life threatening conditions. Symptoms may include drowsiness, confusion, nuchal rigidity, fever, abrupt onset with exertion, described as being “the worst headache I’ve ever experienced,” etc. <p><u>Diagnostic criteria of migraine <i>without</i> aura: At least five attacks fulfilling the following criteria:</u></p> <ol style="list-style-type: none">1. Headache attacks lasting 4-72 hours2. Headache with at least 2 of the following characteristics:<ol style="list-style-type: none">A. Unilateral locationB. Pulsating qualityC. Moderate or severe intensity (interferes with daily activities)D. Aggravated by physical activity such as climbing, walking, bending over3. During the headache, at least one of the following occurs:<ol style="list-style-type: none">A. Nausea or vomitingB. Photophobia or phonophobia <p><u>Migraine <i>with</i> aura includes above plus visual, motor, sensory or speech aura lasting up to 1 hour that <i>begins and resolves</i> prior to headache</u> Examples: Visual-parallel zigzag lines, flashing lights, scotomatous defects. Motor-difficulty moving extremities. Sensory- numbness or</p>

	tingling on one side of face, tongue or fingertips. Speech- mild dysphasia.
OBJECTIVE	<p>Must include:</p> <ol style="list-style-type: none"> 1. Age of client 2. Assessment of current contraceptive practices. 3. Accurate list of current medications including dosage. Some anticonvulsants (phenytoin, lamictal, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine) used for migraine prevention may reduce efficacy of combined contraception. Some interactions, such as with topiramate (Topamax), are dose dependent- i.e. < 200mg/day will not affect combined contraception. With doses higher than 200mg/day a Progestin Only method may be more appropriate. If the anticonvulsant is used for seizure control, combined contraception may reduce the medication levels and increase the risk of seizures. Carefully assess each medication with a trusted drug manual and/or pharmacist. 4. If use of anticonvulsants, other long term contraceptives should be encouraged for women who are long term users of these medications. If combined contraception is used a minimum of 30mcg should be used. 5. Assessment of whether or not migraines are occurring during her menses. If so, she may benefit from shortening or omitting the withdrawal week of a combined contraception method. <p>May include:</p> <ol style="list-style-type: none"> 1. Exam of cranial nerves II-XII
LABORATORY	No specific laboratory indicated. CT scan/MRI may be recommended in certain situations
ASSESSMENT	Headaches
PLAN	<ol style="list-style-type: none"> 1. Clients with history of tension headaches may be treated with OTC NSAIDS if needed and are candidates for all hormonal contraception. 2. Clients with history of migraine headaches <i>without</i> aura are candidates for all hormonal contraception unless >35 years old and developed migraines after initiation of combined hormonal method. If using combined hormonal method, consider using ultra low dose (<20mcg of estrogen) pill or Nuva Ring as some migraineurs are estrogen sensitive. 3. Menstrual migraines may improve with a shortened hormone-free interval or extended regime of combined contraception. 4. Clients with history of migraine headaches <i>with</i> aura are candidates for all contraception <i>except</i> combined hormonal method. 5. Treatment of migraines, at provider's discretion, according to current guidelines such as those outlined at www.migraines.org/treatment
CLIENT EDUCATION	<ol style="list-style-type: none"> 1. Education regarding WHO guidelines, contraindications to combined hormonal methods, etc. Encourage client to notify clinic staff if she ever experiences an aura prior to a migraine. If she is on anticonvulsants, discuss the importance of being forthright with that prescribing provider regarding her hormonal contraception use. 2. Assist client, as indicated, in identifying potential migraine triggers.
CONSULT / REFER TO PHYSICIAN	<ol style="list-style-type: none"> 1. Immediate referral to nearest ER for all headaches indicating potential life threatening illnesses as outlined above. 2. Consult/refer, if needed, for management of migraine headaches.

References:

1. Hatcher, R.A., Trussell,J.,Cates,W.,Kowal,D. (2010) Contraceptive Technology (20th revised edition). New York: Ardent Media:pp, 265, 300.
2. Rakel, R. (2011). Chapter 42 Neurology. In Rakel: Textbook of Family Medicine (8th ed.).
3. Goetz, C. (2007). Headache. In Textbook of Clinical Neurology (3rd ed.). Retrieved from the Web August 7, 2008 <http://mdconsult.com>
4. <http://inhs-classification.org>
5. Centers for Disease Control and Prevention. U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 Adapted from the World Health Organization Medical Eligibility Criteria for Contraception Use, 4th edition. MMWR 2010, 59 June 2010(No. RR-4): pp. 14 and 18. <http://www.cdc.gov/mmwr/pdf/rr/rr5904.pdf>
6. www.rxlist.com