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Headache in Children – A dilemma for Parents and Practitioners

Children are brought for medical consultations with numerous symptoms. As such it becomes the responsibility of the doctor to evaluate such symptoms and come into a reasonable diagnosis based on the history, examination of the patient, the knowledge and past experiences of the clinician. A child presenting with recurrent headache poses a challenge[1] as children are very often unable to express themselves well and are sometimes vague in their descriptions compared to adults. At times they tend to contradict some information they gave earlier and far worse is when their parents are very anxious and fear that the reason for their child's headache is a tumour in the brain or meningitis.

To make matters further complicated, headache is not a symptom confined only to older children and adolescents; even infants and toddlers are affected. However infants and toddlers often express their discomfort differently. Irritability, restlessness, fretfulness and poor feeding are probably manifestations of headache in this age group[1]. Headaches account for almost half of the referrals made to Paediatric neurologists. Fortunately most cases of headache are due to a recognizable cause, but neoplasms, seizure disorders, emotional problems and depression may pose diagnostic difficulties.

Two broad classifications are currently in practice to evaluate headaches in children. The International Headache society (IHS) classification is based on the clinical picture and diagnostic criteria while the other classification is based on the periodicity of symptoms. In clinical practice both classifications are useful in evaluating patients[1-4]. The IHS classification divides headaches into two main categories, i.e. primary and secondary. The primary headache disorders

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do not have a detectable cause and includes childhood migraine, tension type headaches and Trigeminal Autonomic Cephalalgias (TACS). The common causes for the secondary headaches are infection, referred pain from head and neck structures, vascular and nonvascular intracranial disorders, drugs and food additives, head trauma and psychiatric disorders[1,8.9].

In assessing a child with headache it is crucial to determine whether the headache is acute, acute recurrent, chronic progressive, chronic non-progressive or of a mixed type. A carefully taken history and a detailed examination would be the key to achieving this objective. Children below ten years may not be very good at describing pain and getting them to draw and show what they are experiencing could be a very effective way of enhancing the history.

A detailed history includes the onset, warning signs, site of headache, quality of headache, duration, aggravating or relieving factors, periodicity and recurrences[8,9]. Furthermore other accompanying features such as nausea, numbness, vomiting, especially early morning vomiting may be additional clues. A past history of head injury, family members with headache, presence of co-morbid conditions, exposure to drugs, chemicals are some other salient points to be pursued. Information related to the home and school environment which could lead to or aggravate stresses, behavioural disturbances, schooling difficulties, marital disharmony and the remote possibility of sexual abuse are some other causes that could lead to headaches and need to be explored in the history. A short history of a severe headache, accelerated course with vomiting either in sleep or before getting up, altered personality, focal weakness, diplopia, seizures and fever are warning signs and are likely to indicate a secondary cause for the headache which needs urgent diagnostic work up.

Clinical examination includes a detailed central nervous system examination which is no easy task in a child and would require patience, good observation and procedural flexibility[7,8,9]. Examination of fundi and measurement of blood pressure is mandatory. Special areas to examine would include the ears, sinuses, teeth and oral cavity, tenderness of the scalp, cranial bruits and alteration in mental state. Anthropometric measurements including occipito- frontal circumference in smaller children is as important.

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Most clinicians would agree that a reasonable diagnosis or a differential diagnosis is possible after a comprehensive history and your physical findings are likely to confirm your diagnosis. In some instances however, investigations such as blood counts, urinalysis cerebrospinal fluid analysis X-ray of sinuses, EEG and neuro imaging may be needed to confirm diagnosis[8].

Once a diagnosis is established, most children if appropriately managed would get better. Management options include pharmacotherapy, modification of life style, avoiding aggravating factors and support from psychiatrists, parents and teachers to ensure the child is symptom free and could enjoy his or her childhood with good quality of life.

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