

Pediatric Headache Jerzy Sautitz*

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Introduction

Headache is a frequent medical issue in children and adolescents, with the majority of them having a headache by the time they reach adolescence. Pediatric headache symptoms are frequently different from adult headache symptoms, and children may have trouble describing their symptoms. To guarantee proper diagnosis, evaluation, and therapy of the paediatric headache patient, a complete understanding of the methodology is required.

Headaches are a major health concern in both adult and paediatric patients in the United States. The average age of onset is 7.5 years, and by the age of 15, 57%-82% of children will have experienced a headache of some kind. The prevalence of migraines in people aged 15 to 25 years old could be as high as 28%. Boys are more afflicted than females in school-aged youngsters, although there is a female preponderance following puberty. Making the correct diagnosis is crucial for proper workup, counselling, and treatment of headache. Eliciting an acceptable history, completing a pertinent physical exam, and determining whether 'Red Flags' in the history or exam might merit further work-up are all critical steps in this procedure.

Multiple headache kinds are common in paediatric patients, and a thorough history will go over each one in depth. It is important to remember that the focus of history taking should be on the child's reporting, with parents and family members adding clarification and supporting details as needed. Age of first headache and frequency of headaches should be included in historical questions. Differentiating between acute, episodic, chronic progressive and chronic non-progressive headaches can be aided by categorising the onset and temporal pattern of the headache. Episodic and chronic non-progressive headaches are typically linked with primary headache disorders, but acute or chronic progressive headaches may indicate a secondary cause. Ask about the location of the headache, whether it's unilateral or bilateral, and whether it radiates, like in occipital neuralgia. The length of each headache episode is helpful in determining the diagnosis, and in patients with daily headaches, asking about headache-free intervals can help distinguish between headache diagnoses such as chronic migraine and New Daily Persistent Headaches (NDPH). Patients should describe the nature and severity of their pain, albeit these details may be difficult to extract in young children, thus a visual chart like the Wong-Baker Pain faces scale is recommended. Similarly, it's critical to gain a feel of the patient's overall handicap as a result of headaches so you can see how pain affects their everyday life, such as missed school days and/or extracurricular activities. Validated tools like the Pediatric Migraine Disability Assessment, or PedMIDAS, are easy to use and provide a quick assessment of disability to the practitioner. Furthermore, every headache history should include a thorough examination of the symptoms connected with the pain (i.e., prodromal changes in appetite, sleep, or mood, presence

of aura, gastrointestinal symptoms, photophobia, phonophobia, and any comorbid autonomic or orthostatic symptoms). Exacerbating circumstances and headache triggers should be the focus of the following section of the history. Remember to bring out possible correlations with menses, positionality, and time of day, worsening with Valsalva, aerobic/exertional activity, or prolonged screen use while discussing issues. Some children will have identified headache triggers, such as certain meals, strong odours, or changes in the weather. Many lifestyle factors can operate as triggers, and changing one's lifestyle is frequently the first step toward headache relief. As a result, knowing the patient's daily caffeine intake, sleep routine, nutrition, physical activity, and hydration status is beneficial. Furthermore, patients may have discovered pain-relieving elements such as resting down in a dark and quiet area, sitting upright, avoiding movement, or taking particular abortive drugs to screen for possible secondary causes of headache, a full evaluation of systems is required, including queries regarding recent head or neck injuries, fevers, infections, and other symptoms suggestive of systemic disease. Furthermore, a child's past medical history should be examined while getting a headache history, since some underlying conditions, such as diabetes or sleep apnea, can raise headache risk. Direct questions about primary headache diseases, brain tumours, cerebral aneurysms, strokes at a young age, autoimmune disorders, and other problems that may be connected with secondary causes of headaches will be asked as part of the family history. In paediatric and adolescent populations, taking the time to complete a detailed social history, including a HEADSS (Home, Education/Employment, Peer Group Activities, Drugs, Sexuality, and Suicide/Depression) assessment, should not be overlooked, as social and life stressors can be significant contributors to headaches and are often barriers to clinical improvement. Medication overuse headache is common and can be seen in up to 20% of children with chronic headaches. All medications that the patient is taking, including over-the-counter medications and supplements, should be discussed, along with documentation of any failed abortive or

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prophylactic headache medications tried and the frequency of abortive medication use.

All headache patients should have a comprehensive general and neurological examination, with special emphasis paid to focused findings and symptoms that point to secondary headache aetiology. Palpation for sinus discomfort, assessing the temporomandibular joint, palpation of the head/neck for tenderness, trigger points, or muscular tightness, assessment for meningeal symptoms and allodynia, and inspection of the skin for neurocutaneous stigmata are all aspects of the general exam to highlight. Mental status, cranial nerves, strength, sensibility, and reflexes should all be examined for abnormalities or asymmetries during the neurological exam. A gait examination should also be done to check for ataxia. A fundoscopic examination, which includes viewing of the optic disc and assessment of venous pulsations to rule out papilledema, is not considered thorough.

Any 'red flags' suggesting a sinister cause for headaches may be discovered by doing the aforesaid history and physical exam. In a meta-analysis of six trials involving 605 paediatric children

who had headaches and had neuroimaging done, 100% of those confirmed to have an intracranial mass requiring surgery as the source of headaches had abnormal neurologic tests. As a result, even if the exam is abnormal, neuroimaging is recommended. Individuals with headaches lasting less than 6 months and at least one red flag symptom had a 4 % chance of developing a brain tumour, compared to 0.4% for patients with migraines and no red flags. The number of red flags present has a positive connection with the chance of a space-occupying intracranial lesion. Headaches lasting less than six months, confusion, abnormal neurologic exam, lack of visual aura, vomiting, sleep-related headaches, and no family history of migraine were all highlighted as red flags in the study. Progressive course, acute and severe onset, change in headache clinical features, headaches that are usually worse in the morning, worsening with Valsalva, positional headaches, and symptoms of systemic sickness are all regarded warning flags. Headaches in extremely young children, such as those who have little speech, should be treated with special attention because they are more unpredictable.