

BRIEF REPORT

Hemicrania continua postpartum

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Hemicrania continua is a common, but unrecognized headache disorder. We describe two patients with hemicrania continua whose symptoms started in the postpartum period, coined as hemicrania continua postpartum. □ *Hemicrania continua, postpartum*

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Introduction

Hemicrania continua (HC) was previously thought to be a rare disorder, however, recent studies have shown it is a underrecognized primary headache (1).

HC is characterized by a continuous, moderate to severe, unilateral headache, absolutely responsive to indomethacin. Pain exacerbation is frequently accompanied by migrainous (nausea, photophobia, phonophobia) and autonomic features (ipsilateral ptosis, conjunctival injection, lacrimation, nasal congestion) (2, 3).

Hemicrania continua is more prevalent in women than men (2:1), and usually occurs during the reproductive life. Little is known about reproductive life events effects in the course of hemicrania continua. Hemicrania continua postpartum has never been reported.

We report 2 patients with hemicrania continua whose symptoms started in the postpartum period.

Case reports*Case 1*

Case 1 is a 29-year-old white woman with a 2-month history of headaches starting in the postpartum period, 12 h after a cesarean section. The pregnancy was unremarkable, a healthy baby was delivered

without complications. A spinal anaesthesia was performed, however, the headache did not change in quality nor intensity according to position. The headaches were hemicranic, strictly left-sided. A continuous, moderate intensity headache was present and pain exacerbations occurred three to four times a week, lasting six to eight hours. Headaches were accompanied by unilateral tearing, conjunctival injection and a 'sand in the left eye' sensation. Photophobia and phonophobia were present in the exacerbation period, without nausea or vomiting. The patient denied a previous history of headaches. Neurological examination was normal. Magnetic resonance imaging (MRI) of the brain and the MRAngiogram were normal. The patient had complete alleviation of her headache with indomethacin, 75 mg a day. Attempts to decrease the indomethacin dose followed by return of headaches. Three months after initiating therapy the patient had a remission lasting 5 weeks without medication, then the headache returned with the same characteristics and once again responded to indomethacin.

Case 2

Case 2 is a 32-year-old white female with a 2-year history of unilateral headaches after delivery of her first child. The patient denied a previous history of

headaches. Pregnancy was normal and a normal vaginal delivery with local anaesthesia was performed without complications. Her headaches were strictly unilateral, left-sided, fronto-temporal location and of continuous, moderate intensity. Pain exacerbations occurred on a daily basis, lasting four to eight hours. Headaches were accompanied by tearing, ipsilateral to the pain. Photophobia, phonophobia, nausea and vomiting were present during the exacerbation period.

Neurological examination, MRI and MRA of the brain were normal. Acute treatments, including sumatriptan, zolmitriptan, naratriptan, rizatriptan, ergotamine, dipyrone, paracetamol, naproxen and diclofenac, were tried without success. The patient had overused acute medications for one year, but not for the past six months. Preventive medications such as amitriptyline, propranolol and flunarizine, in adequate dosages, also failed even in the absence of rebound headache. The patient had a partial response with indomethacin 75 mg a day and a complete headache relief with 150 mg a day.

Discussion

Hormone-related headaches are common. Migraine is more likely to change during reproductive life events.

Headache generally improves with rising oestrogen levels and worsens with falling levels. It should therefore improve with pregnancy and worsen postpartum. Oestrogen influences pain by its ability to alter neural function, as well as neurotransmitters levels. As oestrogen increases, there is a corresponding increase in peripheral serotonin, resulting in increased inhibition on headache pathways (4).

Although postpartum headaches are usually benign, secondary pathology must be excluded (5).

The differential diagnosis of headache in the postpartum period includes postdural headache, pre-eclampsia, cerebral venous thrombosis, cerebral angiopathy and also primary headaches, particularly migraine.

Stein (6) followed 71 women prospectively during their first postpartum week. Headache occurred in 27 (39%) of the women and was most frequent on days 3–6 post partum. Headache was associated with a previous history or family history of migraine (58% of migraineurs developed headache). These headaches were less severe than the patients' typical migraine headache. Cupini et al. (7) found 7% of patients with migraine without aura started their symptoms in the postpartum period.

Hemicrania Continua has never been reported in the postpartum period. The pathophysiology of hemicrania continua postpartum is unknown.

References

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