Secondary Headaches More Common in Elderly

BY NANCY A. MELVILLE
Contributing Writer

SCOTTSDALE, ARIZ. — Headache management in the elderly involves consideration of factors not often seen in younger patients, Jerry W. Swanson, M.D., said at a symposium sponsored by the American Headache Society.

The possibility of secondary headache is greater in older patients, who often experience polypharmacy and drug interactions, said Dr. Swanson, professor and chair of the division of neurology at the Mayo Clinic Medical School in Rochester, Minn.

Headache ranks as the 10th most common symptom among elderly women and the 14th among elderly men.

Secondary headaches represent one-third of headaches in the elderly, compared with 10% in the general population (Headache 1990;30:273-6).

Typical causes of secondary headaches in the elderly include lesional headaches or cerebrovascular disease—both of which are more common in the elderly—as well as medication-induced headaches.

Giant cell arteritis, a necrotizing, granulomatous arteritis rarely seen before age 50, also should be considered. "New-onset headache is the key with giant cell arteritis," Dr. Swanson said. Other common symptoms of giant cell arteritis include jaw claudication (which occurs in about 40% of cases), fatigue, and fever.

When elderly patients present with a headache, it is important to obtain a detailed history. It's especially important to get a detailed medication history. Why? "Because patients have more medical conditions as they age, you're much more likely to encounter polypharmacy, which increases the risk of drug interactions and side effects," Dr. Swanson said.

Elderly patients are also prone to have a reduced tolerance to those side effects, he pointed out.

Headaches that are associated with medication are often generalized and of mild to moderate severity, and they may be throbbing.

The list of drugs that could be etiologic includes antibiotics, such as tetracycline; bronchodilators; cardiovascular drugs, such as vasodilators and antihypertensives; sedatives and stimulants; antidepressants, such as selective serotonin reuptake inhibitors; and reproductive drugs, such as estrogen.

With secondary headache ruled out, diagnosing and managing primary headaches in the elderly can pose unique challenges and atypical twists. Migraine headaches, for instance, peak in prevalence at about age 40 and are thus less common in the elderly.

That means migraines make up about 8% of headaches in women over age 60 and 3% in men. However, the literature indicates that migraines develop in about 2% of patients over age 50.

Typical causes of secondary headaches in the elderly include lesional headaches, cerebrovascular disease, and medications.

In the elderly, migraine headaches can present with reduced severity and frequency than in younger patients. But there can also be what neurologist C. Miller Fisher, M.D., described as "late-life migraine accompaniments"—including new onset of focal neurologic symptoms, positive visual displays, gradual buildup of visual and sensory symptoms, and serial progression.

Tension-type headaches, though also less common in older age, are more prevalent than migraines, with rates beyond age 65 varying between 27% and 44.5% and higher rates reported among women.

Treatment of migraine or tension-type headaches in older patients can be difficult. It is important to keep in mind that if a prophylactic approach is used with elderly patients, the starting dose should be low and with slow increases, Dr. Swanson said.

Cluster headaches, though also infrequent, are more common among men.

"Virtually all patients for whom a [cluster headache] diagnosis is being entertained should undergo MRI and [magnetic resonance angiography]," he said.

Another type of primary headache, the hypnic headache, has been reported specifically in the elderly and not in younger age groups, he said.

First described in 1988 and still rare, the hypnic headache is a dull one that develops only during sleep, yet with "clocklike regularity." In addition, the hypnic headache is not attributed to any other disorder.

Treatments for the hypnic headache include sleep rationing, lithium, caffeine, or indomethacin, Dr. Swanson noted. ■

U.K. Considers Pulling Four Drugs

Antidementia *from page 1*

dom and the United States. The drugs aren't prohibitively expensive on an individual basis—annual therapy runs about $2,000 per patient—but they cost the NHS the equivalent of $92 million in 2004.

As in the United States, the United Kingdom has projected steadily increasing Alzheimer's drug expenditures, saying spending could exceed $134 million by 2006. The total NHS 2004 budget was about $151 billion. Withdrawing the drugs from the NHS could save $29 million the first year and $115 million by the third year.

The U.K. proposal would have no effect on national policy this side of the Atlantic, said Peter Ashkenaz, spokesman for the Centers for Medicare and Medicaid Services. The federal government has already committed to offering at least two cholinesterase inhibitors as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003. The new coverage will begin in January 2006. Mr. Ashkenaz did not know which two in the class would be covered.

"As long as these drugs are approved by the Food and Drug Administration for Alzheimer's, they will be covered under the new prescription drug benefit," he told this newspaper.

But should the proposal pass, some U.S. dementia experts are concerned about spillover into the policies of private payers and managed care systems. "Insurance companies worldwide are always looking to minimize their expenses," said Samuel Gandy, M.D., professor of psychiatry, neurology, and gerontology at Philadelphia University and director of the Farber Institute for Neurosciences, Philadelphia. "I would predict that the U.S. insurance companies are watching this very closely."

This country's private health care system is a "patchwork" of different companies that make decisions based on both economic and clinical factors, Lon S. Schneider, M.D., said in an interview. A national dictum condemning a class of drugs as not cost effective will get plenty of notice, he predicted. Private payers are really this country's prescription benefits managers, and they are constantly assessing whether the drugs on their formularies are working and are cost effective," said Dr. Schneider, professor of psychiatry, neurology, and gerontology at the University of Southern California, Los Angeles. "They are very interested in the NICE decision and analyses, which may have implications into how these companies manage their pharmacies."

Dr. Lon S. Schneider said NICE's decision on antidementia drugs might influence their coverage by private payers in the United States.

DEAN A. MCCOY/USC/IIC-PHOTO

If the recommendation is accepted, no new prescriptions for antidementia drugs will be written through the NHS, although the drugs will not be withdrawn from patients already taking them.

Physicians, advocacy groups, and families in the United Kingdom have bitterly criticized the proposal, announced on March 1. Critics of the proposal contend that the drugs' true value can't be measured by a single outcome. They also worry that such a decision would contribute to health care disparity in the country.

Britain's health minister, Stephen Ladyman, said his department will ask NICE to reconsider its cost analysis. But the minister also said he would not interfere with NICE's decision-making process.

NICE will render its final recommendation in July. ■

Swollen Joints, Pain May Predict Depression

WASHINGTON — The presence of pain in older adults is a significant risk factor for clinical depression, Stephen Harkins, Ph.D., said at the annual meeting of the Gerontological Society of America.

Poorly managed pain lowers quality of life in older persons across cultures, said Dr. Harkins, professor in the departments of gerontology, psychiatry, and biomedical engineering at Virginia Commonwealth University in Richmond.

He reviewed data on 2,900 adults (mean age 75 years) from the National Health and Nutrition Examination Survey and 2,081 adults (mean age 78 years) from the Australian Longitudinal Study on Aging. Both the American and Australian studies included data on musculoskeletal pain, including swollen joints and hip, back, knee, and neck pain.

Mean scores on the Center for Epidemiologic Studies–Depression (CES-D) scale were similar for older adults in the United States (9.3) and Australia (8.2). Overall, 47% of the adults surveyed reported pain in the past week, and the risk of depression was independently related to the presence, type, and number of musculoskeletal problems.

"The take-home message is that pain increases the probability of scoring high on a depression scale," said Dr. Harkins, who also is director of the psychophysiology and memory laboratory at the university.

—Heidi Splete

Pages 58a—58h