NEW DAILY PERSISTENT HEADACHE IS A PRIMARY HEADACHE DISORDER

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There has been an increased use of the diagnosis of New Daily Persistent Headache. The etiology of this entity is unknown. Is this a primary headache disorder or are there secondary factors?

Abstract of comments

Apparently NDPH is a practical clinical diagnosis at least offering the crucial time for follow-up and paraclinical investigations to clarify potential covered disorders. Both debaters covered the literature related to this disorder answering the principal question of this argues. Although NDPH is coded as 4.8 at the ICHD-II, among the primary headache disorders, a large part of headache specialists agrees that NDPH is most likely a clinical syndrome (Goadsby, 2010). NDPH often requires extensive investigation, for the refractory subtype in particular, which remains resistant even to aggressive treatment. The benign form of NDPH is self-limited and typically goes away within several months, without any treatment frequently. There is a long discussion for the specific diagnostic criteria of NDPH. ICDH-II classification demands absence of any migraine feature, whereas others insist that migraine symptoms are very common in NDPH patients (Robbins et al., 2010). How prevalent NPDH is in general population across the world remains unclear, but recent well-designed studies in Norway revealed that NDPH is rare and occurs in one of 3500 persons from the general population of 30-44-year-olds. It is often associated with medication overuse (Grande et al., 2009). However in a headache specialty clinic NPDH is a frequent diagnosis, covering more than 5% of the patients. Approximately, one out of 15 patients with chronic headache attending a headache center is suffering from NPDH. In pediatric headache centers its frequency is even higher reaching the 10% of chronic headache sufferers (Kung et al., 2009). Often NPDH is related with flu-like infections, the benign sub-form in particular, but again, the mechanistic link between the two situations is elusive. NDPH is considered as an autoimmune-triggered headache in these cases. Brain MRI and CSF examination are required, to exclude two secondary mimics of NPDH: spontaneous CSF leak and cerebral venous thombosis. Sphenoid sinusitis may also mimic NDPH and should be excluded from the differential diagnosis list. The management of NDPH is difficult. Apart from paraclinical investigations, psychiatric and even family and social evaluation is needed to uncover co-morbidities that modify pain perception. Typically NPDH patients will overuse medications soon after the headache onset, if not from the beginning, further indicating the presence of a psychological co-factor either in the pathogenesis, or in the physical history of the disorder. Once this comprehensive evaluation is performed and the patient's puzzle is largely fulfilled, the treatment should target and cover all the possible pathogenetic and comorbide conditions. Thus, not only pharmaceutical but also psychotherapy may be needed. Several agents have been tested with limited efficacy unfortunately, again because of the NPDH-sufferers' heterogeneity. A combination of one antidepressant (SNRI most preferable than SSRI) together with valproate or topiramate is suggested as first choice pharmaceutical treatment. When medication overuse is present, withdrawal of the overused compound is also recommended, although there is a profound debate for the withdrawal timing (prior of the preventive treatment, or simultaneously), as well as for the effectiveness of the drug withdrawal in the case of NPDH in particular. Obviously, prognosis is good for the benign sub-form and bad for the refractory one. Global assessment and multidisciplinary therapeutic approach is fundamental for refractory NDPH. Above and beyond, NDPH remain a challenging situation for the physician and a peculiar condition for the scientist.