

Rhinogenic headache

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Abstract:

Rhinogenic headache was first introduced in ICHD-2 as a limited intermittent pain localized to the periorbital, medial canthal or temporo-zygomatic regions, who have clinical or imaging evidence of mucosal contact points, and in the absence of rhinosinusitis or other significant pathologies within the nasal cavity. It was proposed that the direct correlation of the pain and the contact points should be provided by the relation to postures or abolition of pain within 5 minutes of local anesthetic to middle turbinate, using placebo. Finally, there should be improvement within 7 days of surgery and does not recur.

ICHD-3 made remarkable changes to the previous edition according to the ambiguities in this topic and the vague direct correlation between the presence of contact points and the pain. It replaced the term with a broader one as “headache due to disorders of the nasal mucosa, turbinate or septum”. The localized site of pain was removed in criteria, but the temporal relation and ipsilateral location of the pain to intranasal lesion was insisted for a more precise diagnosis.

The concept of mucosal contact point is widely accepted in real world practice amongst otolaryngologists and head and neck surgeons, despite conflicting studies in the literature regarding a direct relation. This has led to many surgeries for releasing contact points over the world in recent years.

This approach has been changing from a blind one to a rational approach in recent years. Only a limited number of patients with these intranasal pathologies and headache will have benefit from surgical intervention. Patients with migraine who have already a heightened sensitivity of the trigeminal system, may be more susceptible to referred pain following stimulation of trigeminal nerve endings by mucosal contact points in the nasal cavity.

Patients with refractory headache over the face, orbit and frontal areas, who are exacerbated by changes in position, flying or diving, and or associated with persistent symptoms of nasal congestion, and do not respond to adequate treatments for primary headache, do not have explanations such as medication overuse or psychiatric comorbidity, and have a remarkable pathology causing contact points in opposing nasal mucosa should have a consultation for surgery. This could be especially true if the pain is ipsilateral to the nasal pathology and improves with application of topical anesthetic to the side of pathology.

Rhinogenic headache is a hot topic in the field of headache that is prone to misdiagnosis and missed diagnosis. A rational approach with the collaboration of a neurologist and otolaryngologist will give a better result for choosing the limited number of patients who can take benefit from surgical intervention in addition to medical treatment.