

CLINICAL CORRESPONDENCE

Tension-type headache with aura

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There has been considerable discussion in the scientific community on the relation between migraine headache and aura over the last few years and the controversy remains. Auras do not appear to be a migraine-dependent phenomenon.

Auras have been shown to occur with cluster headaches (1), hemicrania continua (2) and chronic paroxysmal hemicrania (3). The International Headache Society Classification for Headache Disorders, published in 1988 (4), did not accept aura with other headache types, but with the current classification published in 2004 (5) another headache type with aura (other than migraine) can be classified and coded as 1.2.2 Typical aura with non-migraine headache.

Tension-type headaches (TTH) are one of the most common headache disorders in the general population (6). TTH is now classified as 2.1 Infrequent episodic tension-type headache, 2.2 Frequent episodic tension-type headache, 2.3 Chronic tension-type headache, and 2.4 Probable tension-type headache. All can be subclassified as with or without pericranial tenderness. Tension-type headache with aura has never been reported in the literature. We report a patient with typical aura with episodic TTH.

Case report

A 55-year-old white male had a 20-year history of episodic headaches, preceded half of the time by visual symptoms characterized by zig-zag lines, starting in the left or right inferior quadrant of the visual field, slowly progressive, increasing the affected area, with a total duration of 15 min. The lines were white and bright followed by a negative scotoma right below the initial aura region, with

a bean-shaped format. The symptoms resolved completely.

As soon as the visual phenomena disappeared, a mild intensity headache started. The pain was described as a dull type headache, in the frontal region bilaterally. The headache was felt as mild for 90% of the time; occasional exacerbation might occur, escalating to a moderate to severe intensity, and the frequency was on average two to three times per month. It was never throbbing in nature, even when the severity increased. No photophobia, phonophobia, osmophobia, nausea or vomiting were reported. Physical activity did not worsen the symptoms. Stress was reported as the only trigger for the headaches. A family history of similar TTH was positive in a brother, but no aura symptoms occurred. The patient denied smoking or heavy alcohol consumption.

A Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-based diagnosis of generalized anxiety disorder was made. Clinical and neurological examination were normal. Ophthalmology did not disclose any ocular disorder. A brain and neck magnetic resonance imaging and magnetic resonance angiography, computed tomography and EEG were all normal. A cardiovascular work-up was also negative, which included ECG, echocardiogram, screening for dyslipidaemias, coagulopathies and diabetes.

Previous treatment for anxiety with venlafaxine 75 mg and bromazepam 6 mg did not alleviate the headaches. Topiramate was started with total resolution of both headaches and auras with 50 mg/day, but was not tolerated by the patient due to cognitive side-effects. Amytriptiline 75 mg/day has satisfactorily controlled the symptoms. No acute treatment is needed for the headaches most of the time, simple analgesics being taken once a month.

Discussion

This appears to be the first description of aura with TTH. Nevertheless, we think that TTH with aura may not be a rare syndrome. In previous epidemiological studies many 'unclassifiable' patients have been reported. Some of these patients may fit the TTH with aura diagnosis. The current second edition of the headache classification now includes the 1.2.2 Typical aura with non-migraine headache. Another explanation for this syndrome never having been reported is that if patients presented one migraine feature, they would fit the probable migraine (previous migrainous disorder) diagnosis rather than TTH with aura. In this case, we could not find any of the classical migrainous symptoms leading to the diagnosis proposed.

The reported case may have implications in the controversy on the relation between migraine headache and aura. This case may represent a new primary headache entity linked to the aura phenomenology. Cluster headache, hemicrania continua, and chronic paroxysmal hemicrania have been described with aura, the existence of TTH with aura adding to the concept that aura is independent of migraine. Migraine aura with non-migraine headache or TTH with migraine aura are also possible diagnoses for this patient; however, the aura phe-

nomenology in this case is not linked to any migraine feature. It is unlikely that the patient's aura is linked to migraine. The modular headache theory is a way of understanding TTH with aura, accepting that the modules bilateral headache, dull pain type and aura may coexist.

Further studies on patients with other primary headaches than migraine linked to aura are needed for a better understanding of the issue. Genetic and functional imaging studies may help clarify the mechanisms underlying aura and headaches.

References

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