Geriatric Pain Management Guide: Headache in Older Patients

Discussion: Though headache prevalence declines with advancing age, it is not uncommon for elderly to complain of one. Headaches in this population tend to be different than in those of younger persons and are more commonly associated with vascular disease, head trauma, and neoplasms, where urgent intervention becomes increasingly important (Bamford, Mays, & Tepper, 2011). Fifteen percent of headaches in this age group are caused by serious, potentially life-threatening disorders (Walker & Wadman, 2007). When nurses understand different headache presentations, prompt assessment can be completed and early intervention provided. Being able to differentiate between nonemergent and emergent headaches is critical.

Headache Condition:

NONEMERGENT	Who gets it / Key History	Key Signs & Symptoms	Management
Migraine HA	Prevalence: without prior hx, new-onset is unusual after age 65 (2%); 50% if prior hx Some have just the aura, no HA (reversible visual or sensory s/s)	**Unilateral** (one-sided), **pulsating** often with N, V, and light sensitivity with or without aura PE: normal neuro exam	Non-pharmacologic: cool compress to forehead, lie down in dark room, and call provider
Tension HA (most common)	Prevalence: 44.5% over age 65 Triggers: lack of sleep and emotional or physical stress	Constant ***bilateral*** **tightening** pressure; (can mimic a more worrisome cause) PE: bilateral mild/moderate pain not worsening with ADLs + a normal neuro exam = **reassuring**	Non-pharmacologic: Stress management and Tylenol or NSAID where indicated; call provider
Med-induced HA (elders with hx of episodic migraine can transform to chronic daily headache if taking analgesics frequently enough)	Prevalence: fairly common with polypharmacy in this population **Which meds**: indomethacin, nifedipine, atenolol, Bactrim, isosorbide dinitrate, & methyldopa; **Med-overuse or misuse HA**: barbiturate-analgesic-caffeine combos, codeine, opioids, caffeine, Tylenol, ASA, & NSAIDS	Med-overuse HA: **Daily or near-daily HA associated** with overuse or misuse of "pain relievers" (listed to the left); appears to interfere with the brain centers worsening HA pain	Call provider; may be instructed to tapering offending analgesic
• Rhinosinusitis • Chronic Sinusitis	Prevalence of chronic sinusitis: 14.1% over 65; 13.5% over 75; Hx of thick nasal drainage	**Nasal obstruction, discharge** & congestion; facial pressure/pain, HA, loss of smell, halitosis	Call provider; may try saline nasal irrigation to provide humidification
HA from Cervical spine disease	Prevalence: nearly universal with aging (as cervical degenerative disk disease is so common)	**One side** of the head/doesn't change sides, is **triggered** by neck movement, or sustained by awkward neck positions; PE: may have shoulder pain/stiff neck on same side	Call provider

EMERGENT	Who gets it / Key History	Key Signs & Symptoms	Management
Bleed in the head Subarachnoid hemorrhage Minor aneurysm leak can produce a "sentinel headache" days to weeks before rupture	Highest incidence: women > 70 Most occur during the morning or evening hrs.	**Sudden onset** of the "worst headache" in her/his life (can occur in **any location**, mild, resolve, or may be relieved by analgesics) N&V – common (75%), also syncope, neck pain, coma, confusion, lethargy, & seizure	**Call 911**, alert provider
Vasculitis Giant Cell Arteritis "Temporal arteritis"	Incidence: ↑ after age 50; > in 70-80's **Can lose vision permanently**	**Unilateral HA** over **temporal**/occipital area, visual changes, & hurts to chew **PE**: thick, tender nodularity over temporal artery region	Alert provider urgently; may have standing order to get an ESR
Stroke/CVA	Stroke can present with HA (up to 17%)	Described as dull or throbbing; mild to severe; **diffuse <u>or</u> on one side** associated with vomiting	Alert provider urgently
Brain tumor (Intracranial lesion)	Incidence ↑ with age; 61% are metastases	Classic: **severe morning HA** that worsens on positional change/assoc. with N&V Elderly: <u>closely resembles a tension HA-must ask what makes it worse</u>	Alert provider
Infection Meningitis/encephalitis	Usually viral HSV-1 most common for encephalitis	HA, fever, and mental status changes; nuchal rigidity	Alert provider urgently
Acute Glaucoma Angle closure glaucoma	Prevalence: ↑ with age, more common in elderly women	**Unilateral HA** with associated with blurred vision, N&V **PE**: fixed pupil/globe of eye feels rock-hard	Alert provider urgently, **"ocular emergency"**

Initial Nursing Care: Initial nursing care starts with good assessment to identify the probable type of headache.
Any patient who has a headache and focal neurologic abnormality requires emergent neuroimaging to exclude an intracranial lesion.

Physical Exam: Obtain as many specifics of the headache pattern as possible (duration, distribution, severity, radiation, prior hx, precipitating/alleviating factors, any fall or trauma).

Your neuro exam should start with assessment of mentation and pay special attention to cranial structures checking for scalp and facial tenderness over the affected area (s).

Typical Treatments/Meds:
If an urgent headache is ruled out, then a trial of rest, cool compress, and/or decreased lighting is indicated and is a nursing measure. If the resident has orders for symptomatic treatment for specific symptoms, initiate those treatments or administer medicines. If trauma preceded the head pain, resident should assume most comfortable position of rest while awaiting ambulance transfer.

Communication: (SBAR)

- **S**ituation: What is happening at present time? Describe the symptoms, location, and degree of pain.
- **B**ackground: What led up to this situation? Resident may have awakened with the symptoms; may have been brought on by exercise, or just appeared suddenly. Was there any trauma associated with this onset of pain? Does the resident have a history of a similar occurrence, if so – when and what relieved the pain?
- **A**ssessment or Appearance: Report physical exam results, vitals. What are the results of physical exam (redness, swelling, warmth to touch, presence of Heberden's nodes or tophi)? What do you or the resident think is going on?
- **R**equest: What do you think should be done to correct the problem? Meds, lab work or tests, monitor, other?

References

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