The prevalence and diagnosis of headache in an urban practice

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SUMMARY. During a six-month study, one person in every 24 of the practice population consulted us about headache. There were more than twice as many females as males, and the largest group of females was in the 20 to 40 year age group.

The majority of patients were managed entirely in the practice; only 10·4 per cent were investigated and four per cent were referred to hospital. The commonest cause was tension. Two patients had headaches due to serious pathology and one of these died.

Introduction

HEADACHE was found to be the ninth commonest symptom in one general-practice study (Morrell, 1972). A survey by Waters and O'Connor (1971) of a random group of females aged between 20 and 44 years who kept health diaries showed that headache was the commonest symptom.

Undergraduate medical education emphasizes the rare, serious diagnoses at the expense of the common, often trivial ones. Despite the significant contribution which headache makes to the workload of a general practitioner, few studies of prevalence and diagnosis have been published (Fry, 1955; Milne, 1965; Waters, 1970).

Aim

A prospective study was designed to determine the prevalence of headache in a single-handed urban practice of 3,000 patients from 1 May 1977 to 31 October 1977. We attempted to make an accurate diagnosis in each patient with headache.

Method

During the study period we recorded every consultation by a patient with headache either in the surgery or in the patient's home. The headache was recorded if it occurred alone or in association with other symptoms. Only headaches volunteered by the patient were included. Details of the patient's name, age, sex, accompanying symptoms, and results of clinical examination were recorded.

At the end of the study period the records were examined so that the number of consultations and results of investigations and hospital referral could be analysed. On the basis of this information an original provisional diagnosis and a final diagnosis were made according to the classification of the Ad Hoc Committee (1962).

Results

One hundred and twenty-five patients (four per cent of the practice population) made 192 consultations for headache (four per cent of the total consultations in the six-month period). The age and sex distribution of these patients is shown in Table 1.

Table 1. Age and sex distribution of patients with headache.

Age (Years)	Males	Females	Males percentage of total	Females percentage of total
0-9	5	5	*4*	*4*
10-19	7	10	*5.6*	*8*
20-29	7	19	*5.6*	*15.2*
30-39	4	21	*3.2*	*16.8*
40-49	6	8	*4.8*	*6.4*
50-59	3	9	*2.4*	*7.2*
60-69	6	8	*4.8*	*6.4*
70-79	1	4	*0.8*	*3.2*
80-89	—	2	—	*1.6*
Totals	39	86	*31.2*	*68.8*

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Table 2. Diagnoses made in a series of patients seen with headache.

Diagnosis	Males	Females	Total	Diagnosis	Males	Females	Total
Tension (including depression)	7	31	38	*Drug side effects*			
Migraine	4	12(a)	16	Oral contraceptive	—	3	3
Migraine and tension (requiring treatment for both)	—	3	3	Dydrogesterone ('Duphaston')	—	1	1
Cervical arthrosis	1	2(b)	3	Glyceryl trinitrate	—	1	1
Infections				?Subarachnoid haemorrhage	1(d) (e)	—	1
Sinusitis	7	5	12	Trauma	—	1	1
Upper respiratory tract	5	9	14	Hypoglycaemia	—	1	1
Tonsillitis	1	3	4	Cough	—	1	1
Bronchitis	1	2	3	Noise	1	—	1
Gastroenteritis	2	1	3	Trigeminal neuralgia	—	1	1
Labyrinthitis	—	2	2	Vasomotor rhinitis	—	1	1
Influenza	1	—	1	'Periodic syndrome' of childhood	1	—	1
Otitis media	1	—	1	Hiatus hernia	1(c)	—	1
Pyelitis	—	1(c)	1	Malingering	1	—	1
Herpes zoster	—	1	1	Unknown	3	5[2(d)]	8

(a) One patient also had headache due to trauma.
(b) One patient also had headache due to oral contraceptive.
(c) Patient admitted to hospital.
(d) Patient referred to outpatient clinic.
(e) Patient died.

Table 3. Investigations performed in patients presenting with headache.

X-ray cervical spine	3
Haemoglobin and ESR	3
OSCI (optician's eye examination)	3
Dip slide urine test	1
ECG	1
X-ray sinuses	2

The diagnoses are shown in Table 2. Ninety-seven patients were examined (77·6 per cent of total); 13 patients were investigated (10·4 per cent of total; Table 3); three patients were referred to outpatient clinics (2·4 per cent of total); and two patients were admitted to hospital (1·6 per cent of total).

The age distribution of the practice population closely followed that for Gt Britain as a whole except that there were fewer in the under-14 age group and more in the over-65 age group for both sexes (Table 4).

Table 4. A comparison of the age and sex distribution of the practice population with the population of Gt Britain (1971 mid-year estimates, Office of Population Censuses and Surveys, 1977).

	Males (figures in percentages)		Females (figures in percentages)	
Age group (years)	Mid-year estimates 1971	Study practice	Mid-year estimates 1971	Study practice
0-14	*25.4*	*19.2*	*22.8*	*19.2*
15-19	*7.3*	*9.2*	*6.6*	*6.4*
20-29	*15*	*13.7*	*13.9*	*13.9*
30-44	*18.2*	*17*	*16.9*	*18.5*
45-64	*23.8*	*26.8*	*24.2*	*23.7*
65+	*10.2*	*13.9*	*15.6*	*18.1*

Discussion

In our study, headache was found to be commonest in females in the 20 to 40 year age group. The commonest diagnosis, tension, that is, muscle contraction headache due to anxiety or depression, was four times more common in females than males.

The diagnosis was based mainly on the history and clinical examination. Investigations were few and the results often negative. In eight patients (six per cent of the total) no diagnosis could be made. Investigations were performed on two of these and a further two were referred to outpatient clinics. All eight patients were further observed and the headache subsided completely.

In two patients serious causes were found. One was a

34-year-old woman who was admitted to hospital with clinical evidence of meningism and was found to be suffering from pyelitis. The second was a 69-year-old man who presented initially with classic features of tension headache—continuous tight pain in a hat-band distribution only partially relieved by analgesics. Later he developed diplopia and ataxia and was referred urgently to a neurologist. Investigation revealed a lesion in one parietal region but whilst in hospital he developed features resembling acute subarachnoid haemorrhage and rapidly died. Postmortem examination has failed to reveal the precise diagnosis, but further results are awaited.

Conclusion

Although diagnostic techniques have advanced during recent years, our study has shown that headache remains largely a problem for the general practitioner. Diagnosis is often extremely difficult and demands a high degree of clinical skill as well as a detailed knowledge of the patient's background.

Most headaches, whilst troublesome, are self-limiting and not particularly serious. Nevertheless, we must be vigilant and recognize potentially catastrophic headaches at an early stage.

References

Ad Hoc Committee on Classification of Headache (1962). *Journal of the American Medical Association,* **179,** 717-718.
Fry, J. (1955). *Transactions of the Hunterian Society,* **14,** 130-149.
Milne, J. S. (1965). *Scottish Medical Journal,* **10,** 251-253.
Morrell, D. C. (1972). *Journal of the Royal College of General Practitioners,* **22,** 297-309.
Office of Population Censuses and Surveys (1977). *The General Household Survey 1974.* London: HMSO.
Waters, W. E. (1970). *Headache,* **9,** 178-186.
Waters, W. E. & O'Connor, P. J. (1971). *Journal of Neurology, Neurosurgery and Psychiatry,* **34,** 148-153.

The need to ask

There can be a clash in the consultation between the patient's objective which is to *ask* for advice and treatment, and the doctor's need to *ask* for information on which to build his diagnosis and base his advice. This clash of asking may be avoided by encouraging the patient to talk and teaching the doctor to listen. One way is for the doctor to avoid starting his questions with a verb: such as "Does it . . .?", "Are you . . .?", or "Can he . . .?", to which the answers need be only "yes" or "no". Instead he can say: "Tell me about so and so", or "When did it start", "What do you feel?", or "How sore is that?".

Reference

Watson, G. I. (1978). Address to the South West Thames Faculty Annual Dinner. Unpublished.

Copying psychiatric records

The question with any copy is how many are made, who reads them, where they are to be filed, and who will have access to the files. It is doubtful if satisfactory answers with the requisite guarantee of continous security and confidentiality can ever be given regarding copies or extracts from case notes, for they never engender the same respect as the original.

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Reference

Royal College of Psychiatrists (1977). *News and Notes.* January, p. 7.

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