

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/rethinkingmigraine/could-there-be-a-secondary-cause-for-your-patients-migraine/9968/>

ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Could There Be a Secondary Cause for Your Patient's Migraine?

Opening Announcer:

This is ReachMD. Welcome to this special series, *Rethinking Migraine*, sponsored by Lilly. On this episode, titled *Advanced Migraine Assessments* we will hear from Dr. Rashmi B. Halker Singh, Assistant Professor of Neurology and director of the Headache Fellowship Program at the Mayo Clinic in Phoenix, Arizona

Dr. Singh:

When a patient comes to see me for a headache, the first thing I have to do is to make sure that they don't have a secondary cause for their headache problem. I can do this by asking a lot of screening questions. There is a very easy mnemonic that you can use to make sure you ask all the right questions to screen for secondary causes of headache. The mnemonic is SNOOP⁴ Red Flags.

So SNOOP, the first "S" stands for any systemic signs or symptoms. In other words, does the patient have a malignancy? Are they complaining of any systemic symptoms like fever or weight loss that might point you in a direction of a secondary cause?

The "O" stands for any neurologic signs or symptoms. If they have any focal neurologic deficits they're complaining about, like vision loss, double vision; you see any papilledema on your funduscopic exam, you should be worried about a secondary cause of headache.

The first "O" stands for onset. So if a patient comes to see you and they're complaining about a headache, rather than headaches, you might want to ask them, how did this headache begin? Did it reach peak intensity within 60 seconds of onset, like a clap of thunder. If so, you should do a thorough evaluation looking for secondary causes including neuroimaging.

The next "O" stands for older age of onset. We all know that migraine, other primary headache problems, do occur for a first time in older individuals; however, as people get older, secondary cause of headache also become more common. So if the patient is over the age of 50 and has a new-onset headache, you should do a thorough investigation looking for possible secondary explanations.

The first "P", so SNOOP⁴, so there are 4 P's.

The first "P" stands for any progressive headache history. So this headache evolving from an episodic picture to something that now's become chronic and daily.

The second "P" stands for any positional component to their headache; actually a positional trigger to their headache. So, does the headache come on only when they're supine or only when they're upright? If so, there might be a problem of CSF pressure.

The next "P" stands for precipitation by Valsalva. So if the headache is brought on by coughing, sneezing, or other Valsalva maneuvers, this patient should have imaging done to make sure there's nothing in the posterior fossa that could be causing it.

The last "P" stands for previous headache history. So if they have a previous headache history, but what they're having now is new or different, you need to take this as a new problem and start fresh.

There's also one more "P" to think about that is not in the mnemonic and that's pregnancy. So if this is a pregnant patient that's complaining about a new headache you should be worried about possible secondary causes as well.

If you've asked all these questions and you feel confident that your patient does not have a secondary headache problem, but rather migraine, the next two things to think about are:

- Is their acute treatment optimized?

- Are they taking their acute medication at headache onset?
- What's their most bothersome symptom with their migraine attack? If it's nausea and vomiting, are you treating that? In other words, does your patient need an antiemetic? Or do they need a non-oral acute treatment so that they're not vomiting the treatment again?
- And also, how often are they having their headaches, and how often are they needing to take acute treatment? If the answer to either of those questions is more than once or twice a week then you should think about putting them on a daily preventative medication.

So again, don't forget to SNOOP⁴ Red Flags, review their acute treatment option, and consider putting your patient on a prophylactic if they're having more than one or two headache attacks per week.

Closing Announcer:

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