

An unusual presentation of daily headache: A case report

Neena Sanjiv Sawant¹, Tanvi Shashank Vaidya², Niharika Tushar Shah³, Karishma Ilyas Rupani⁴

From ¹Professor; ²3rd year Resident, ³2nd year Resident, ⁴Assistant Professor, Department of Psychiatry, Seth Gordhandas Sunderdas Medical College and King Edward Memorial Hospital, Mumbai, Maharashtra, India

Correspondence to: Neena S Sawant, Department of Psychiatry, Seth Gordhandas Sunderdas Medical College and King Edward Memorial Hospital, Acharya Dhonde Marg, Parel, Mumbai - 400 012, Maharashtra, India. E-mail: drneenas@yahoo.com

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ABSTRACT

Headache is a fairly common universal symptom caused by multiple etiologies. More than 90% of headaches are primary headaches which are tension-type headaches and migraines. The rest are secondary headaches that have an underlying local or systemic cause. Most often, there could be underlying psychopathology, where the headache would be the presenting symptom. Life stresses, depression, anxiety, and relationship issues are often seen in headache patients. We report a case that was referred to psychiatry from the medicine outpatient department for tension-type headache but had an underlying organic etiology, though it was detected only after thoroughly evaluating the patient with liaison with neurology and ear, nose, and throat doctors.

Key words: Cluster, Headache, Migraine, Neurology

Each year, on average, 46–53% of people have headaches, commonly tension-type or migraine as primary headaches, whereas secondary headaches have an underlying local or systemic cause [1,2]. Most of the headaches are not life-threatening. Only approximately 1–5% of headaches are due to a serious underlying cause [3]. It is imperative to rule out the underlying systemic condition for headache management.

We report a case who was referred for tension-type headache but had an underlying organic etiology. It is important for clinicians to, therefore, look for other causes of headache which may seem very trivial, but nonetheless, their diagnosis and management help in giving relief and improving the quality of life of the patient.

CASE REPORT

A 38-year-old married housewife was referred to the psychiatry outpatient department (OPD) for the evaluation of headache. The headache had started 1.5 years back and was mild, holocranial, occasionally radiating toward the neck and upper back, lasting for 15–30 min, frequency of 2–3 per week, and currently subsiding with non-steroidal anti-inflammatory drugs (nonsteroidal anti-inflammatory drugs; tablet naproxen 500 mg). She had also been given a trial with paracetamol 650 mg and ibuprofen 400 mg as and when required, by her family physician to which she had no relief of the pain. There was no precipitating factor, vomiting, photophobia, or phonophobia.

For 1.5 months, the patient described a change in the nature and quality of the headache. The pain used to progressively increase and associated with epiphora, periorbital puffiness, and

tenderness on palpation on the left side sometimes lasting for 5–10 min, sometimes for an hour or two, being relieved only on medication. There was no rhinorrhea, diplopia, or signs of external ophthalmoplegia. There was no pain-free interval in between and mild holocranial headache always used to persist. She had 4–5 such episodes daily which gradually increased over the month with rare occasions of no episodes for a day or two. She revealed no features suggestive of anxiety or depression preceding the onset of headache. There was no change in her sleep, appetite, diet, or lifestyle nor any major life events. The patient had no significant medical/surgical history or substance consumption. The patient was admitted for evaluation of her headache and appropriate investigations.

On general examination, the patient was afebrile, pulse was 82/min, and her blood pressure was 110/70 mm of Hg on her right arm in the supine position. During her stay, the patient had an episode with conjunctival suffusion and local swelling of the lacrimal punctum on the affected side with epiphora. There was periorbital swelling on inspection and tenderness on palpation even over zygomatic prominence. On neurological examination, the patient had mid-dilated pupils, sluggishly reactive to direct right reflex on the affected side. However, all the cranial nerves tested were intact, and there was no sensory or motor deficit.

Her systemic examination, routine blood investigations, and thyroid function tests were within normal limits. Neurology opinion was taken and the patient was given a trial of tablet rizatriptan (10 mg) once a day and tablet amitriptyline 25 mg at night for 5 days without any improvement. Further thinking of hemicranias, we continued tablet indomethacin 25 mg thrice a day for 7 days.

The patient progressively had increased pain and periorbital swelling failed to subside. Magnetic resonance imaging brain (plain+contrast) revealed normal brain study and the left maxillary sinusitis. Ear, nose, and throat (ENT) opinion were taken and a computed tomography (CT) scan of paranasal sinuses (PNS) was advised, which revealed features suggestive of the left maxillary and the left ethmoidal invasive fungal sinusitis with the erosion of the left floor of orbit with an extension of soft tissue into the left nasolacrimal duct (Fig. 1).

The patient was transferred the ENT for functional endoscopic sinus surgery (FESS). After the procedure, the patient's unilateral pain, along with the swelling, completely resolved. She was asked to follow-up in the ENT OPD on a regular basis. The patient had no active management from psychiatry, all headache medications were withheld and she was asked to follow-up in psychiatry OPD if needed.

DISCUSSION

This patient had a headache as the presenting and only complaint entirely different in quality, constantly varying in intensity, with new acute symptoms on the existing chronic onset. It is necessary for every physician to evaluate headache. A multi-disciplinary approach was adopted in the management as no psychological causes were evident. She was, however, anxious, timid, and getting easily worried kind of person. She was referred from general OPD to consider tension headache or cluster headache as she had associated episodic lacrimation with redness of eyes. But since admission, the patient started getting increased acute on chronic episodes of headache and periorbital swelling always used to be associated with lacrimation. Differential diagnoses considered were cluster headache and rare types of migraine-like ophthalmic migraine and short-lasting unilateral neuralgiform headache with conjunctival injection and tearing is the expansion of SUNCT.

Cluster headache may lead to ipsilateral swelling of the eyes with redness, lacrimation, lid edema, and pain [4]. Due to its

propensity to maintain periodicity, it is also known as "alarm clock headache." Our patient did not have periodicity and had persistent inter-episodic swelling. A transitory Horner's syndrome observed in two-thirds of the patient during the attack was absent in our patient [4]. In migraine, the least common presentation is the lid edema. When an ophthalmic migraine is diagnosed, it improves with medications for migraine. All the above were ruled out as the patient had no diplopia, ptosis, blind spots, or transient visual obscurations or episodes had no autonomic disturbance with longer durations, as seen in SUNCT. The patient also did not improve on migraine medications.

As the swelling used to fail to subside completely, we thought that there would be an underlying organic cause. Hence, an ENT opinion with the right investigation revealed the cause, though the classical presentation was not there. In fungal infections of orbit, the primary site of infection is the sinus. The most common of orbital fungal infections is mucormycosis and aspergillosis. However, these invasive infections generally occur in an immunocompromised host. Their early signs include fever, nasal discharge, epistaxis, nasal mucosal ulceration, and periorbital pain. However, all these symptoms are gradual and not occurring at the same time to cause orbital symptoms immediately. After the invasion of orbit, symptoms such as periorbital edema and proptosis are observable [5].

We did not find any literature on case reports similar to ours, though fungal sellar abscess mimicking pituitary neoplasm with headache as a presenting symptom has been cited by several researchers which were also found to be a rare presentation [6,7]. Hong *et al.* found that treatment with antifungal drugs and endoscopic transsphenoidal surgery was most effective in the treatment of their patient [6].

Coexisting periorbital cellulitis or a local tumor around the orbit with sinusitis obstructing the nasolacrimal duct can paint such a clinical picture like our patient. However, ruling out the other local causes put forth a rather confusing picture as to why the periorbital swelling used to occur if it was due to sinusitis. Malignancy was suspected, which was ruled out on CT PNS which was suggestive of invasive fungal sinusitis that eroded the orbital floor leading to the periorbital swelling. After doing the FESS, the only reason for the periorbital swelling was an incidental small deformity on the floor of orbit which was not very conspicuous and would have gone unnoticed otherwise. Such incidental findings can often be missed and may result in improper diagnosis and treatment of the patient. Imaging and simple surgical procedures do turn out to be the best modalities for a perfect diagnosis and an appropriate treatment in patients with confusing clinical pictures.

CONCLUSION

As clinicians, we see a lot of patients, who come with the symptom of headache which often gets better with over the counter drugs. However, certain symptoms could be misleading and the pain can create havoc in the person's life. Ruling out each diagnosis with the necessary treatment paradigm and evaluation

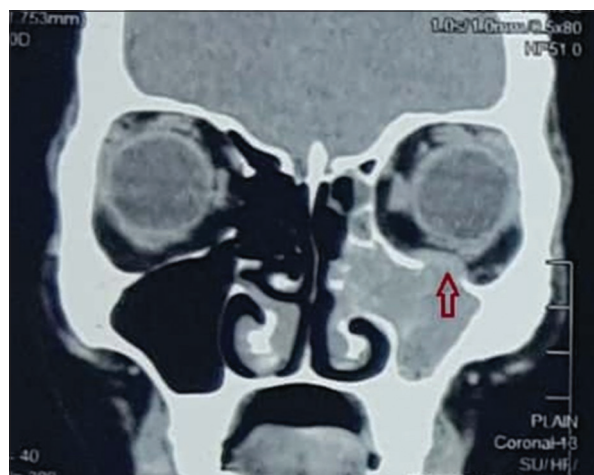


Figure 1: Computed tomography Paranasal sinus showing features suggestive of the left maxillary and the left ethmoidal invasive fungal sinusitis

of improvement is, therefore, the most precise clinical tool for every physician.

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