Impatto sulla pratica clinica della nuova classificazione ICHD-3

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1988

Headache Classification Committee of the International Headache Society

CLASSIFICATION AND DIAGNOSTIC CRITERIA for HEADACHE DISORDERS, CRANIAL NEURALGIAS and FACIAL PAIN

(IHS)

2004

INTERNATIONAL CLASSIFICATION of HEADACHE DISORDERS ***2nd edition***

(ICHD-2)

2018

INTERNATIONAL CLASSIFICATION of HEADACHE DISORDERS ***3rd edition***

(ICHD-3)

Principi ispiratori e strutturazione

- Sistematizzazione delle diverse forme di cefalea (sia primarie che sintomatiche) secondo **livelli progressivi di raffinatezza diagnostica**

  primi 2 livelli di competenza di tutti i medici;
  livelli successivi di competenza dello specialista

- Per ogni forma di cefalea individuata:
  - terminologie precedenti
  - definizione
  - **precisi criteri diagnostici** — puramente clinici
  - commento

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Headache Classification Committee of the International Headache Society (IHS)

The International Classification of Headache Disorders, 3rd edition

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ICHD-3	How to use this classification

“This extensive document is not intended to be learnt by heart. Even members of the Classification Committee are unable to remember all of it. It is a document that should be consulted time and time again. ….."

ICHD-3

La ICHD-3, così come le precedenti edizioni (ICHD-2, 2004 e IHS, 1988), ordina e definisce gli attacchi di cefalea, NON I PAZIENTI

ICHD-3, 2018
vs
ICHD-2, 2004

- Modifiche
  - Differenti denominazioni
  - Differenti collocazioni
  - Differenti criteri diagnostici
- Novità
  - Nuove forme

ICHD-3, 2018

Differenti denominazioni

Part one: the primary headaches

1. Migraine
2. Tension-type headache
3. Trigeminal autonomic cephalalgias ← *3. Cluster headache and other trigeminal autonomic cephalalgias (ICHD-2, 2004)*
4. Other primary headache disorders

Part two: the secondary headaches

5. Headache attributed to trauma or injury to the head and/or neck
6. Headache attributed to cranial or cervical vascular disorder
7. Headache attributed to non-vascular intracranial disorder
8. Headache attributed to a substance or its withdrawal
9. Headache attributed to infection
10. Headache attributed to disorder of homoeostasis
11. Headache or facial pain attributed to disorder of the cranium, neck, eyes, ears, nose, sinuses, teeth, mouth or other facial or cervical structure
12. Headache attributed to psychiatric disorder

Part three: painful cranial neuropathies, other facial pains and other headaches

13. Painful cranial neuropathies and other facial pains
14. Other headache disorders

1. Migraine

ICHD-3, 2018

Differenti denominazioni

1.1 Migraine without aura

1.2 Migraine with aura

- 1.2.1 Migraine with typical aura
  - 1.2.1.1 Typical aura with headache
  - 1.2.1.2 Typical aura without headache
- 1.2.2 Migraine with brainstem aura
- 1.2.3 Hemiplegic migraine
  - 1.2.3.1 Familial hemiplegic migraine (FHM)
    - 1.2.3.1.1 Familial hemiplegic migraine type 1 (FHM1)
    - 1.2.3.1.2 Familial hemiplegic migraine type 2 (FHM2)
    - 1.2.3.1.3 Familial hemiplegic migraine type 3 (FHM3)
    - 1.2.3.1.4 Familial hemiplegic migraine, other loci
  - 1.2.3.2 Sporadic hemiplegic migraine
- 1.2.4 Retinal migraine

Emicrania basilare (ICHD-2, 2004)

1.3 Chronic migraine

1.4 Complications of migraine

- 1.4.1 Status migrainosus
- 1.4.2 Persistent aura without infarction
- 1.4.3 Migrainous infarction
- 1.4.4 Migraine aura-triggered seizure

1.5 Probable migraine

- 1.5.1 Probable migra
- 1.5.2 Probable migra

Sindromi periodiche dell'infanzia possibili precursori dell'emicrania (ICHD-2, 2004)

1.6 Episodic syndromes that may be associated with migraine

- 1.6.1 Recurrent gastrointestinal disturbance
  - 1.6.1.1 Cyclical vomiting syndrome
  - 1.6.1.2 Abdominal migraine
- 1.6.2 Benign paroxysmal vertigo
- 1.6.3 Benign paroxysmal torticollis

1. Migraine

ICHD-3, 2018

Differenti collocazioni

1.1 Migraine without aura

1.2 Migraine with aura

- 1.2.1 Migraine with typical aura
  - 1.2.1.1 Typical aura with headache
  - 1.2.1.2 Typical aura without headache
- 1.2.2 Migraine with brainstem aura
- 1.2.3 Hemiplegic migraine
  - 1.2.3.1 Familial hemiplegic migraine (FHM)
    - 1.2.3.1.1 Familial hemiplegic migraine type 1 (FHM1)
    - 1.2.3.1.2 Familial hemiplegic migraine type 2 (FHM2)
    - 1.2.3.1.3 Familial hemiplegic migraine type 3 (FHM3)
    - 1.2.3.1.4 Familial hemiplegic migraine, other loci
  - 1.2.3.2 Sporadic hemiplegic migraine
- 1.2.4 Retinal migraine ← *1.4 Retinal migraine (ICHD-2, 2004)*

1.3 Chronic migraine ← *1.5.1 Chronic migraine (ICHD-2, 2004)*

1.4 Complications of migraine

- 1.4.1 Status migrainosus
- 1.4.2 Persistent aura without infarction
- 1.4.3 Migrainous infarction
- 1.4.4 Migraine aura-triggered seizure

1.5 Probable migraine

- 1.5.1 Probable migraine without aura
- 1.5.2 Probable migraine with aura

1.6 Episodic syndromes that may be associated with migraine

- 1.6.1 Recurrent gastrointestinal disturbance
  - 1.6.1.1 Cyclical vomiting syndrome
  - 1.6.1.2 Abdominal migraine
- 1.6.2 Benign paroxysmal vertigo
- 1.6.3 Benign paroxysmal torticollis

3. Trigeminal autonomic cephalalgias ICHD-3, 2018

Differenti collocazioni

4.7 Hemicrania continua (ICHD-2, 2004) → 3.4 Hemicrania continua

3.1 Cluster headache

- 3.1.1 Episodic cluster headache
- 3.1.2 Chronic cluster headache

3.2 Paroxysmal hemicrania

- 3.2.1 Episodic paroxysmal hemicrania
- 3.2.2 Chronic paroxysmal hemicrania

3.3 Short-lasting unilateral neuralgiform headache attacks

- 3.3.1 Short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT)
  - 3.3.1.1 Episodic SUNCT
  - 3.3.1.2 Chronic SUNCT
- 3.3.2 Short-lasting unilateral neuralgiform headache attacks with cranial autonomic symptoms (SUNA)
  - 3.3.2.1 Episodic SUNA
  - 3.3.2.2 Chronic SUNA

3.4 Hemicrania continua

- 3.4.1 Hemicrania continua, remitting subtype
- 3.4.2 Hemicrania continua, unremitting subtype

3.5 Probable trigeminal autonomic cephalalgia

- 3.5.1 Probable cluster headache
- 3.5.2 Probable paroxysmal hemicrania
- 3.5.3 Probable short-lasting unilateral neuralgiform headache attacks
- 3.5.4 Probable hemicrania continua

1. Migraine

ICHD-3, 2018

Differenti criteri diagnostici

1.1 Migraine without aura

1.2 Migraine with aura

- 1.2.1 Migraine with typical aura
  - 1.2.1.1 Typical aura with headache
  - 1.2.1.2 Typical aura without headache
- 1.2.2 Migraine with brainstem aura
- 1.2.3 Hemiplegic migraine
  - 1.2.3.1 Familial hemiplegic migraine (FHM)
    - 1.2.3.1.1 Familial hemiplegic migraine type 1 (FHM1)
    - 1.2.3.1.2 Familial hemiplegic migraine type 2 (FHM2)
    - 1.2.3.1.3 Familial hemiplegic migraine type 3 (FHM3)
    - 1.2.3.1.4 Familial hemiplegic migraine, other loci
  - 1.2.3.2 Sporadic hemiplegic migraine
- 1.2.4 Retinal migraine

1.3 Chronic migraine

1.4 Complications of migraine

- 1.4.1 Status migrainosus
- 1.4.2 Persistent aura without infarction
- 1.4.3 Migrainous infarction
- 1.4.4 Migraine aura-triggered seizure

1.5 Probable migraine

- 1.5.1 Probable migraine without aura
- 1.5.2 Probable migraine with aura

1.6 Episodic syndromes that may be associated with migraine

- 1.6.1 Recurrent gastrointestinal disturbance
  - 1.6.1.1 Cyclical vomiting syndrome
  - 1.6.1.2 Abdominal migraine
- 1.6.2 Benign paroxysmal vertigo
- 1.6.3 Benign paroxysmal torticollis

1. Migraine

ICHD-3, 2018

Nuove forme

1.1 Migraine without aura

1.2 Migraine with aura

- 1.2.1 Migraine with typical aura
  - 1.2.1.1 Typical aura with headache
  - 1.2.1.2 Typical aura without headache
- 1.2.2 Migraine with brainstem aura
- 1.2.3 Hemiplegic migraine
  - 1.2.3.1 Familial hemiplegic migraine (FHM)
    - 1.2.3.1.1 Familial hemiplegic migraine type 1 (FHM1)
    - 1.2.3.1.2 Familial hemiplegic migraine type 2 (FHM2)
    - 1.2.3.1.3 Familial hemiplegic migraine type 3 (FHM3)
    - 1.2.3.1.4 Familial hemiplegic migraine, other loci
  - 1.2.3.2 Sporadic hemiplegic migraine
- 1.2.4 Retinal migraine

1.3 Chronic migraine

A 1.3.5 Benign paroxysmal torticollis (ICHD-2, 2004)

1.4 Complications of migraine

- 1.4.1 Status migrainosus
- 1.4.2 Persistent aura without infarction
- 1.4.3 Migrainous infarction
- 1.4.4 Migraine aura-triggered seizure

1.5 Probable migraine

- 1.5.1 Probable migraine without aura
- 1.5.2 Probable migraine with aura

1.6 Episodic syndromes that may be associated with migraine

- 1.6.1 Recurrent gastrointestinal disturbance
  - 1.6.1.1 Cyclical vomiting syndrome
  - 1.6.1.2 Abdominal migraine
- 1.6.2 Benign paroxysmal vertigo
- 1.6.3 Benign paroxysmal torticollis

4. Other primary headache disorders

ICHD-3, 2018

Nuove forme

4.1 Primary cough headache

4.1.1 Probable primary cough headache

4.2 Primary exercise headache

4.2.1 Probable primary exercise headache

4.3 Primary headache associated with sexual activity

4.3.1 Probable primary headache associated with sexual activity

4.4 Primary thunderclap headache

4.5 Cold-stimulus headache

A 13.7.1 Nummular headache (ICHD-2, 2004)

4.5.1 Headache attributed to external application of a cold stimulus

4.5.2 Headache attributed to ingestion or inhalation of a cold stimulus

4.5.3 Probable cold-stimulus headache

4.5.3.1 Headache probably attributed to external application of a cold stimulus

4.5.3.2 Headache probably attributed to ingestion or inhalation of a cold stimulus

4.6 External-pressure headache

4.6.1 External-compression headache

4.6.2 External-traction headache

4.6.3 Probable external-pressure headache

4.6.3.1 Probable external-compression headache

4.6.3.2 Probable external-traction headache

4.7 Primary stabbing headache

4.7.1 Probable primary stabbing headache

4.8 Nummular headache

4.8.1 Probable nummular headache

4.9 Hypnic headache

4.9.1 Probable hypnic headache

4.10 New daily persistent headache (NDPH)

4.10.1 Probable new daily persistent headache

1.1 Migraine without aura

1.3 Chronic migraine

2 Tension-type headache

3 Trigeminal autonomics cephalalgias

8.2 Medication overuse headache

1.1 Migraine without aura

1.3 Chronic migraine

2 Tension-type headache

3 Trigeminal autonomics cephalalgias

8.2 Medication overuse headache

Diagnostic criteria:

A. At least five attacks[1] fulfilling criteria B–D
B. Headache attacks lasting 4–72 hours (when untreated or unsuccessfully treated)[2,3]
C. Headache has at least two of the following four characteristics:
   1. unilateral location
   2. pulsating quality
   3. moderate or severe pain intensity
   4. aggravation by or causing avoidance of routine physical activity (e.g. walking or climbing stairs)
D. During headache at least one of the following:
   1. nausea and/or vomiting
   2. photophobia and phonophobia
E. Not better accounted for by another ICHD-3 diagnosis.

1.1 Migraine without aura

1.3 Chronic migraine

2 Tension-type headache

3 Trigeminal autonomics cephalalgias

8.2 Medication overuse headache

1.1 Migraine without aura

1.3 Chronic migraine

2 Tension-type headache

3 Trigeminal autonomics cephalalgias

8.2 Medication overuse headache

2.1 Infrequent episodic tension-type headache

2.1.1 Infrequent episodic tension-type headache associated with pericranial tenderness

2.1.2 Infrequent episodic tension-type headache not associated with pericranial tenderness

2.2 Frequent episodic tension-type headache

2.2.1 Frequent episodic tension-type headache associated with pericranial tenderness

2.2.2 Frequent episodic tension-type headache not associated with pericranial tenderness

2.3 Chronic tension-type headache

2.3.1 Chronic tension-type headache associated with pericranial tenderness

2.3.2 Chronic tension-type headache not associated with pericranial tenderness

2.4 Probable tension-type headache

2.4.1 Probable infrequent episodic tension-type headache

2.4.2 Probable frequent episodic tension-type headache

2.4.3 Probable chronic tension-type headache

Diagnostic criteria:

A. At least 10 episodes of headache occurring on 1–14 days/month on average for >3 months (≥12 and <180 days/year) and fulfilling criteria B–D
B. Lasting from 30 minutes to seven days
C. At least two of the following four characteristics:
   1. bilateral location
   2. pressing or tightening (non-pulsating) quality
   3. mild or moderate intensity
   4. not aggravated by routine physical activity such as walking or climbing stairs
D. Both of the following:
   1. no nausea or vomiting
   2. no more than one of photophobia or phonophobia
E. Not better accounted for by another ICHD-3 diagnosis.[1]

1.1 Migraine without aura

1.3 Chronic migraine

2 Tension-type headache

3 Trigeminal autonomics cephalalgias

8.2 Medication overuse headache

1.1 Migraine without aura

1.3 Chronic migraine

2 Tension-type headache

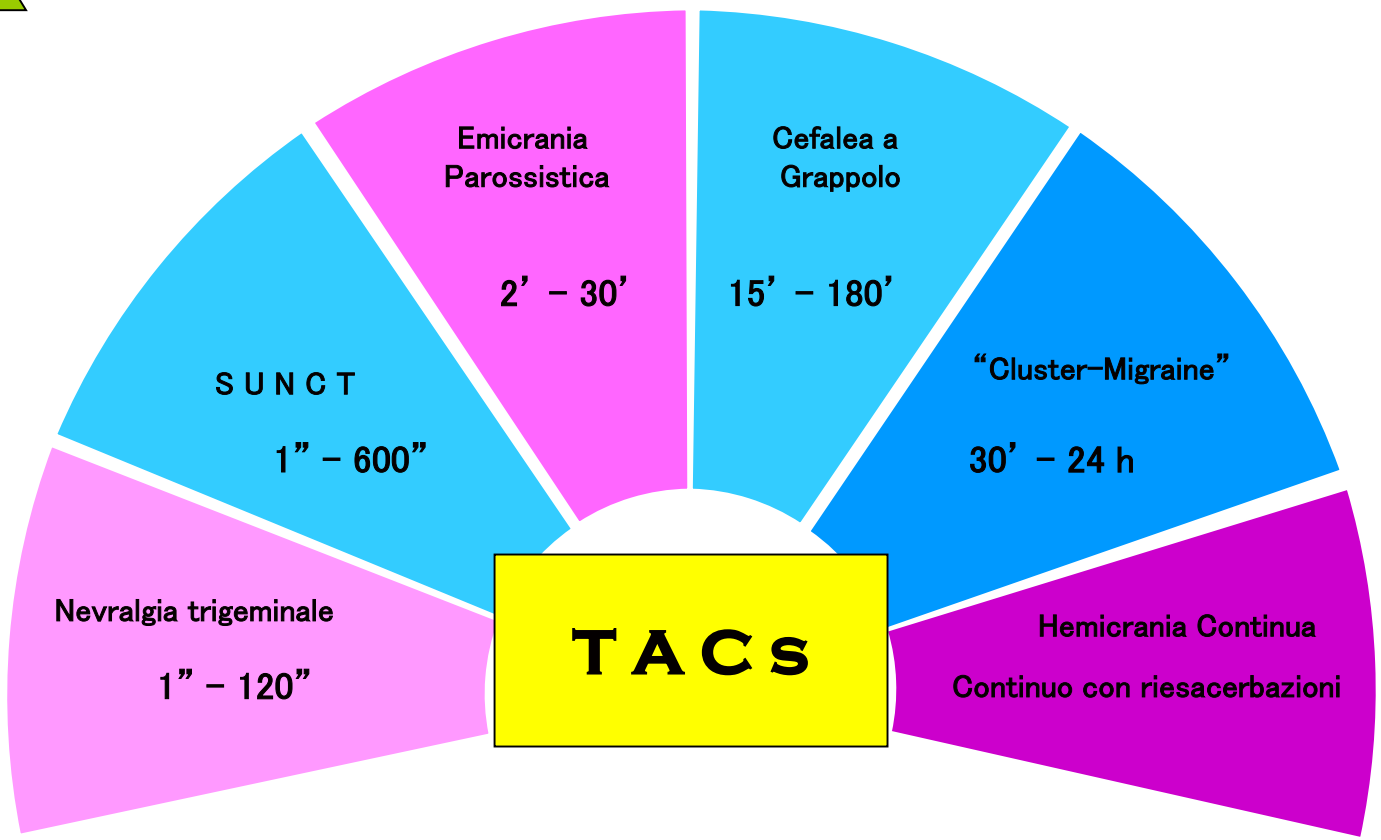
3 Trigeminal autonomics cephalalgias

8.2 Medication overuse headache

3. Trigeminal autonomic cephalalgias (TACs)

- 3.1 Cluster headache
  - 3.1.1 Episodic cluster headache
  - 3.1.2 Chronic cluster headache
- 3.2 Paroxysmal hemicrania
  - 3.2.1 Episodic paroxysmal hemicrania
  - 3.2.2 Chronic paroxysmal hemicrania
- 3.3 Short-lasting unilateral neuralgiform headache attacks
  - 3.3.1 Short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT)
    - 3.3.1.1 Episodic SUNCT
    - 3.3.1.2 Chronic SUNCT
  - 3.3.2 Short-lasting unilateral neuralgiform headache attacks with cranial autonomic symptoms (SUNA)
    - 3.3.2.1 Episodic SUNA
    - 3.3.2.2 Chronic SUNA
- 3.4 Hemicrania continua
  - 3.4.1 Hemicrania continua, remitting subtype
  - 3.4.2 Hemicrania continua, unremitting subtype
- 3.5 Probable trigeminal autonomic cephalalgia
  - 3.5.1 Probable cluster headache
  - 3.5.2 Probable paroxysmal hemicrania
  - 3.5.3 Probable short-lasting unilateral neuralgiform headache attacks
  - 3.5.4 Probable hemicrania continua

Fenomeni vegetativi



Lo Spettro delle “Trigeminopatie”

1.1 Migraine without aura

1.3 Chronic migraine

2 Tension-type headache

3 Trigeminal autonomics cephalalgias

8.2 Medication overuse headache

1.1 Migraine without aura

1.3 Chronic migraine

2 Tension-type headache

3 Trigeminal autonomics cephalalgias

8.2 Medication overuse headache

1.5.1 EMICRANIA CRONICA

Criteri diagnostici ICHD-2, 2004

1. **Cefalea che soddisfi i criteri C e D per 1.1 *Emicrania senza aura* per ≥ 15 giorni / mese da > 3 mesi**

2. **Non attribuita ad altra condizione o patologia**

Nota

Assenza di uso eccessivo di farmaci

New appendix criteria open for a broader concept of chronic migraine

Headache Classification Committee: J Olesen, M-G Bousser, H-C Diener, D Dodick, M First, PJ Goadsby, H Goebel, MJA Lainez, JW Lance, RB Lipton, G Nappi, F Sakai, J Schoenen, SD Silberstein & TJ Steiner (*Cephalalgia 2006;26:742-746*)

Appendix 1.5.1 Chronic migraine

A. Headache (tension-type and/or migraine) on ≥15 days per month for at least 3 months

B. Occurring in a patient who has had at least 5 attacks fulfilling criteria for 1.1 Migraine without aura

C. On ≥8 days per month for at least 3 months, headache has fulfilled C1 and/or C2 below, that is, has fulfilled criteria for pain and associated symptoms of migraine without aura

1. Has at least two of a-d
   - (a) unilateral location
   - (b) pulsating quality
   - (c) moderate or severe pain intensity
   - (d) aggravation by or causing avoidance of routine physical activity (e.g. walking or climbing stairs)

   and at least one of a or b
   - (a) nausea and/or vomiting
   - (b) photophobia and phonophobia

2. Treated and relieved by triptan(s) or ergot before the expected development of C1 above

D. No medication overuse and not attributed to another causative disorder

1.3 CHRONIC MIGRAINE

Diagnostic criteria:

A. Headache (migraine-like or t
≥15 days/month for >3 mon
teria B and C

B. Occurring in a patient who has had at least five attacks fulfilling criteria B–D for 1.1 *Migraine without aura* and/or criteria B and C for 1.2 *Migraine with aura*

C. On ≥8 days/month for >3 months, fulfilling any of the following[2]:
   1. criteria C and D for 1.1 *Migraine without aura*
   2. criteria B and C for 1.2 *Migraine with aura*
   3. believed by the patient to be migraine at onset and relieved by a triptan or ergot derivative

D. Not better accounted for by another ICHD-3 diagnosis.[3–5]

ICHD-3,2018
Non è più presente:
"No medication overuse"

EMICRANIA CRONICA (ICHD-3, 2018)

Soggetti che

- **in passato hanno avuto crisi di emicrania**
- **ora presentano da oltre 3 mesi almeno 15 giorni di cefalea al mese dei quali almeno 8 di tipo emicranico**
- **non hanno una *medication overuse***

E se un paziente ha una cefalea che rispetta i criteri diagnostici per EMICRANIA CRONICA, ma ha anche un OVERUSE DI SINTOMATICI?

1.3 CHRONIC MIGRAINE

ICHD-3, 2013

Notes:

…….. **patients meeting criteria for 1.3 *Chronic migraine* and for 8.2 *Medication-overuse headache* should be coded for both.**

ICHD-3, 2013

8.2 Medication-overuse headache (MOH)
- 8.2.1 Ergotamine-overuse headache
- 8.2.2 Triptan-overuse headache
- 8.2.3 Non-opioid analgesic-overuse headache
  - 8.2.3.1 Paracetamol (acetaminophen)-overuse headache
  - 8.2.3.2 Non-steroidal anti-inflammatory drug (NSAID)-overuse headache
    - 8.2.3.2.1 Acetylsalicylic acid-overuse headache
  - 8.2.3.3 Other non-opioid analgesic-overuse headache
- 8.2.4 Opioid-overuse headache
- 8.2.5 Combination-analgesic-overuse headache
- 8.2.6 Medication-overuse headache attributed to multiple drug classes not individually overused
- 8.2.7 Medication-overuse headache attributed to unspecified or unverified overuse of multiple drug classes
- 8.2.8 Medication-overuse headache attributed to other medication

Diagnostic criteria:

A. Headache present on ≥15 days/month

B. Ergotamine on ≥10 days/month on a regular basis for >3 months

or

Triptan (any formulation) on ≥10 days/month on a regular basis for >3 months

or

Simple analgesics on ≥15 days/month on a regular basis for >3 months

or

Opioid on ≥10 days/month on a regular basis for > 3 months

or

Combination medications on ≥10 days/month on a regular basis for > 3 months

or

Multiple drug classes not individually overused on ≥10 days/month on a regular basis for > 3 months

or

Unverified overuse of multiple drug classes on ≥10 days/month on a regular basis for > 3 months

Classification means deciding on which kinds of diagnostic entities should be recognised and how to order them in a meaningful fashion. In doing so, one should draw upon all kinds of available evidence: clinical description, longitudinal studies of cohorts of patients, epidemiological studies, treatment results, genetics, neuroimaging and pathophysiology.

(From Introduction to the ICHD-2, 2004)

Medication overuse headache – comments on the current International Headache Society classification criteria

(Cephalalgia 2010;30:1410-1411)

Author's reply

The ultimate question that needs to be discussed by the scientific community is not how to better classify MOH, but if MOH should exist as a single entity or is more appropriately viewed as a risk factor.

(Marcelo E Bigal, C Sun-Edelstein, Alan M Rapoport)

1.3 Chronic migraine

L’emicrania cronica, così come attualmente definita nella ICHD-3 rappresenta in modo adeguato i pazienti affetti da questa particolare forma di cefalea?

8.2 Medication overuse headache

Anche prescindendo dalla discussione sull’esistenza - almeno per alcune delle forme individuate - come entità cliniche autonome, quale validità hanno i criteri diagnostici stabiliti nella ICHD-3?

Caso 1

Donna di 45 anni, coniugata, impiegata. La madre aveva sofferto di emicrania.
Non fuma, ciclo mestruale regolare. Nulla di rilevante nell'anamnesi patologica remota.

Dall'età di 18 anni attacchi di emicrania senza aura.
Nei primi 4-5 anni dall'esordio, gli attacchi hanno una frequenza variabile da 1 a 3 volte al mese ed una durata di 1-2 giorni con buona risposta ai sintomatici (FANS). Dopo la laurea, in concomitanza con l'inizio dell'attività lavorativa, gli attacchi aumentano di frequenza (circa 1 alla settimana, più facilmente nei giorni liberi dal lavoro). Le crisi di emicrania si risolvono quasi del tutto in corrispondenza dell'unica gravidanza a termine all'età di 29 anni, ma si ripresentano dopo il parto ed in particolare dopo la fine del periodo di circa 6 mesi di allattamento, fino a riportarsi ad una frequenza non superiore a 1 alla settimana e mantenendo una buona risposta ai FANS.

La paziente si presenta al nostro Centro Cefalee perché nell'ultimo anno, in concomitanza con preoccupazioni famigliari (malattia della madre che necessita di costante assistenza da parte della paziente), gli attacchi sono aumentati progressivamente di frequenza fino a manifestarsi, ormai da circa 6 mesi, 5-6 volte al mese.
Gli attacchi continuano ad avere le solite caratteristiche cliniche tipiche dell'emicrania senza aura, ma sono aumentati d'intensità e, non rispondendo più ai FANS che era abituata ad utilizzare (ibuprofene 600 mg per os e/o ketoprofene 100 mg per via rettale o parenterale) , si protraggono per 3 giorni consecutivi. La paziente, al momento della prima osservazione al Centro, non ha mai effettuato alcuna terapia preventiva e non ha mai utilizzato i triptani come sintomatici.

Diagnosi ICHD-3: CM - MOH

Caso 2

Donna di 52 anni, coniugata, artigiana. Famigliarità positiva per emicrania (madre e ava materna). Non fuma, ha avuto 2 gravidanze a termine; menopausa a 50 anni.
Tra i dati anamnestici patologici, ipotiroidismo dall'età di 35 anni (Eutirox 75 cinque giorni alla settimana), ipertensione arteriosa dall'età di 47 anni (attualmente ben controllata con bisoprololo 2,5 mg e ramipril 5 mg). Inoltre, dall'età di 40 anni circa soffre di depressione ed insonnia per le quali sta assumendo citalopram 20 mg e lorazepam 2,5 mg alla sera prima di coricarsi.

Ha iniziato a soffrire di emicrania senza aura, soprattutto perimestruale, intorno ai 22-23 anni d'età e, fino all'età di 37-38 anni con l'eccezione dei periodi corrispondenti alle 2 gravidanze quando la situazione era migliorata anche se non del tutto risolta, la frequenza degli attacchi era di 1-2 alla settimana, ognuno della durata di 1-2 giorni con ottima risposta al Difmetre supp. (indometacina + proclorperazina + caffeina).
Dopo i 38 anni, la frequenza è andata via via aumentando e le caratteristiche cliniche delle crisi si sono gradualmente modificate: il dolore non è più a partenza anteriore ma posteriore, non è più sempre unilaterale, non è più presente vomito, è mediamente di minore intensità ma il Difmetre è meno efficace nonostante un maggior utilizzo. Dall'età di 40 anni circa, la cefalea è presente tutti i giorni con solo poche ore di attenuazione dopo le singole assunzioni di Difmetre supp.

Si presenta al nostro Centro Cefalee perché non ha tratto benefici dalle diverse terapie preventive attuate (flunarizina, pizotifene, amitriptilina, topiramato), ha provato ad utilizzare come sintomatici i triptani senza alcun risultato e non è più in grado di condurre una normale vita lavorativa e famigliare nonostante l'utilizzo, da ormai un paio d'anni, di 4-5 supposte di Difmetre ogni giorno.

Diagnosi ICHD-3: CM - MOH

Conclusions and *take home messages*

- **La classificazione ordina i tipi di mal di testa. Un paziente può averne più tipi**
- **I limiti sono spesso rigidi o schematici**
- **Non tutte le forme possono essere faclmente classificate**
- **Sicuramente vi sono incongruenze cliniche**

- **È l'unico modo per cercare di mettere ordine in un campo che ha una complessità unica**
- **Tende a omogeneizzare i pazienti, soprattutto a fini di studio**
- **Fornisce elementi per dare risposte a quesiti specifici**
- **Tenta una correlazione fra quadro clinico e risposta, o quantomeno indicazione, terapeutica**