CEPHALALGIA – A MODERN TYPE OF NIGHTMARE

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ABSTRACT

One of the most frequent disorders presenting to the neurology clinic is headache; nonetheless, a considerable fraction of these patients express dissatisfaction with their clinical outcome. The diagnosis of this illness might be simple or complex, and although headaches are mostly benign, they can be an indication of animus. With an emphasis on migraine, cluster headaches, tension-type headaches, and different kinds of daily headaches, this study addresses the current diagnosis, classification, and therapeutic principles of headache disorders.

KEYWORDS: Headache, migraine, threatening, primary headache, secondary headache, pharmacological, non-pharmacological, prevention, trigger factors.

INTRODUCTION

Even though it gets less frequent with age, headaches are a typical ailment in the elderly. A few headaches are so severe that they severely impair a person's quality of life, resulting in enormous expenses for medical treatment and, in turn, for the overall economy. most people able to well managed by a general practitioner or primary care physician with a precise clinical diagnosis that doesn't require more study. Cluster headaches and migraine tension headaches are the main types of headache disorders. Secondary headaches should be taken seriously because they can be fatal.[4] As stated by the Global Health Organization, headaches rank among the best 10 disabilities, and among the top 5 in women. Their effects are comparable to those of diabetes and arthritis, but they are worse than those of asthma. A CNS system infection is suggested by headaches that are accompanied by a fever, rash, decreased or altered level of awareness.[2] Young women are more likely to experience headaches from cerebral venous thrombosis, especially if they smoke or use oral contraceptives.[4] In addition to early morning headache, nausea, altered awareness, and seizures, An increased intracranial existence is the disease's defining feature.[3]

Headache categorization

Since its first publication in 1988, the Headache Disorders International Classification (ICHD) has undergone two updates, the most recent of which took place in 2013.

Section 1: Headache principal
1. Magraine
2. Headache of the tense type
3. The neural autonomic cephalalgia
4. Additional major headache conditions

Section 2: The Symptoms of headache That Are In additional - Pain in the head [Or Face Pain] Caused By;
5. Head and/or neck trauma or damage
6. Illness of the cervical or skull vessels
7. Non-vascular brain conditions.
8. One substance or its discontinuation.
9. Contamination
10. A homeostasis disorder
11. An illness affecting the head, neck, eyes, nose, sinuses, teeth, mouth, or any other part of the face or cervical region.Psychiatric disorders.

Section 3: Severe Cerebral Neuropathies, Extraoral Pain, and Headache
12. Painful cranial neuropathies other facial pains
13. Additional headache conditions.[2]

Handling of Headache
1. The best headache treatment
Go to a quiet, dark room and rest.Apply warm or cool compresses to your head or neck, take a few modest doses of coffee, and receive a massage. mostly used for over-the-counter medication such as ibuprofen (Advil, Motrin 1B, etc.), aspirin, and acetaminophen (Tylenol, etc.).[6]

Personal Care
The following medications may help with headache pain:

ibuprofen, aspirin, and Paracetamol. Another possible solution is to rest in a dimly lit room.

Getting Medical Attention
➢ See a doctor immediately if you :
➢ Feel worse than normal headache
➢ Get a sudden, severe headache
➢ Become confused, slur your speech or faint
➢ Any troubles in seeing, speaking or the walking
➢ If you experience nausea or vomiting.

Path physiology of chronic migraine
The initial vascular theory of migraine was based on the assumption that pervascular nerves innervating the major cerebral vessels would become activated, thereby initiating a migraine attack. Given that both the peripheral and central neural systems work in concert to generate migraines, it looks that migraine is a complicated disorder.[9] Uncertain underlying processes confound the pathophysiology of cluster headaches. The effects of trigeminal-autonomic reflex activation are what cause vascular cerebral alterations in cluster headaches, which are neurovascular in nature as opposed to vascular. The pineal gland secretes melatonin, and the suprachiasmatic nucleus, which receives sympathetic innervations from the hypothalamus and autonomic centers of the thoracic spinal cord, the sympathetic cervical plexus, and the carotid plexus, controls the rate of secretion of this hormone in a strong circadian rhythm. Light intensity is the primary environmental cue for the daily generation of melatonin, and the retina provides a direct channel for this information to reach the suprachiasmatic nucleus of the hypothalamus.[9]

Pharmacological management for cephalalgia
Headaches of a tension-type, or TTH
The most typical type of headache and one that with the largest socioeconomic costs is tension type headache (TTH).[10]

Appropriate dosages of analgesics, such as acetaminophen or NSAIDS (ibuprofen, naproxen sodium), can be used to treat mild to moderate TTH.[11]

On the other hand, patients who experience severe or persistent TTH should be sent to a physician for treatment that goes beyond over-the-counter (OTC) medication.[11]

MIGRAINES
The incapacitating neurological ailment known as migraine usually manifests as a unilateral, pulsing headache, sensitivity to stimuli, nausea, and vomiting.[12]

Adequate dosages of analgesics, like acetaminophen or NSAIDS, can effectively cure mild to moderate migraines.[11]

Risk factors
Anxiety, sadness, social isolation, animosity, work stress,

and psychosocial risk variables were assessed through the use of standardized self-administered questionnaires. The current study's psychosocial risk variables were selected based on the European 2012 guidelines for the prevention of cardiovascular disease in clinical practice, given that the PORTAAT study primarily looks at cardiovascular risk factors.[13]

ANXITY
The instrument employed to assess anxiety was the Generalized Anxiety Disorder 7-Item Scale (GAD-7). For generalized anxiety, an 89% sensitivity and an 82% specificity are present in a score of 10 or above. The overall score is a number between 0 and 21, where 0 and 4 denotes little to no concern, 5 and 9 suggest some anxiety, 10 and 15 indicate significant anxiety, and 16 and 21 denote extreme anxiety. In.[14]

DEPRESSION
To quantify mood disorders, the major depressive inventory (MDI) was employed.[15] The MDI questionnaire is self-rated and consists of ten items. It assesses depressive symptoms over the last two weeks using a 6-speak Likert type scale, with zero indicating never and 5 representing always. A high score denotes a high frequency of symptoms associated with depression, and a serious [moderate to severe] depression is indicated by an optimum cut-off score of 26. From 0 to 50 is the total score.

SOCIAL ISOLATION
The ENRICHD brief social assistance inventory (ESSI)[16] was used to study social isolation. The ESSI's six components gauge how much social support they receive on a scale of one to five (0 being never to 4 being regularly). A higher level of social isolation is indicated by a lower score. The range of the overall score is zero to 25. In study examining headaches and migraines this questionnaire is being utilized for the first time.

Hostile
The cynical distrust scale, a self-administered questionnaire with eight questions assessed on a 5-indicate Liker scale from completely disagree to completely agree, was used to measure the degree of animosity.[17] The overall score ranges from 9 to 32, with a lower value denoting a higher degree of animosity. This questionnaire is being used for the first time in a headache population in this investigation.

WORKSTRESS
Utilizing the finish this Bergen Burnout Index BBI-[15][18], labour-related tension was assessed. The BBI-15 uses 15 questions to assess occupational burnout. Likert-type scales with 1 denoting absolutely disagree and 6 denoting completely agree are used to provide the answers. The scales are added up to produce a score between 15 and 90, with an elevated score shows a significant amount of strain at labour. The present research is the first that uses this questionnaire especially

for people with headache.

HEADACHE MANAGEMENT WITHOUT PHARMACOLOGY

These non-pharmacological treatments may be effective on their own or in conjunction with medicine to provide improved pain relief, depending on the severity of the pain.

➢ Learn stress management skills and try relaxation techniques.
➢ Think about suggesting to your patient that they keep a headache journal.
➢ Advise rest in a dark and quiet room.
➢ Adjusting their life style,
➢ This includes cutting back on coffee, making sure you workout frequently, and preventing erratic or insufficient sound sleep.[11]
➢ Develop a consistent sleeping routine.

ANALYSIS AND STATESTICS

After the information were loaded into an encrypted records, data analysis was performed using EPI Infotech and SPSS 15.[19]

A software system used the recorded survey replies to make diagnoses rather than the interviewers themselves. Those who reported having headaches more than fifteen days a month were first divided into a separate group and given a diagnosis of probable major illness (PMOH). Those who took major headaches medicine on a daily basis for no less than ten days per month were classified as probable MOH. The method employed the ICHD-II diagnostic criteria, which are as follows: migraine, TTH, likely migraine, probably TTH, for all other cases. For the purpose of estimating prevalence and doing additional analyses, instances of headaches and likely headache as well as tension type headache [TTH] and likely [TTH] were pooled. The remaining cases were not categorized.[19]

The statistical characteristics of each factor were summarized using proportions, confidence intervals of ninety-five percent (CIs), medians, means, and standard deviations (SDs). The significance of differences was assessed using chi-squared, Student's t-test, or ANOVA. In bivariate analysis, we computed odds ratios (ORs) to test for relationships, and in multivariate logistic regression, we computed adjusted odds ratios (AORs). The significance threshold was set at 5%.[19]

RESULTS

1,142 [48.0 %] males, 1,189 [52.0 %] females, mean age 38.1 [±12.8] years, 1,104 [47.5 %] from rural areas, and 1,227 [52.8 %] from urban areas made up the 2,331 participants. Ninety-six percent of the eligible population participated overall (n = 2,515). The primary reason for non-participation (103 out a city 58 rural) was unavailability for interview even after three contacts, despite the fact that there were very few real refusals (25 a city 0 rural). The participating sample's gender, age, and habitation distributions have been documented; they were similar to those of the Karnataka population.[19]

PREVALENCE

In the study population, the crude one-years frequency of any kind headaches (n = 1,488) was 63.8%, along with a majority of females (74.0 % versus 54.4 % in men; OR = 2.3 [1.9-2.7]) and a preponderance of rural people (71.2 % versus 57.3 % urban; OR = 1.8 [1.6-2.1]). This work includes additional analysis broken down by type of headache.

On a crude 1-year prevalence measure, there were 25.6% (95 % CI: 23.9-27.4%); 10.8% [9.7-12.2 %] definite and 14.8% [13.4-16.3 %] probable migraine cases (n = 597). According to Table 1, prevalence was greater in women (32.4%) compared to men (18.6%; OR = 2.1 [1.7-2.6]) and in people from rural areas (29.7%) compared to those from urban areas (21.8 %; OR = 1.6 [1.4-1.7]).

Table 1: Gender, chronological age, and location- residence-specific migraines frequency during a whole year (N = 598).

Age (years)	One-year prevalence n (%) [95 % CI]								
	Urban habitation			Rural habitation			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
17-24	22 (17.5) [12.1-25.1]	28 (21.9) [15.5-29.7]	50 (19.5) [15.1-24.8]	17 (19.1) [12.2-28.6]	28 (25.8) [18.8-34.6]	45 (23.1) [17.5-29.2]	38 (18.2) [13.5-23.7]	59 (23.6) [18.8-29.4]	97 (21.2) [17.7-25.2]
25-35	31 (18.8) [13.7-25.1]	68 (32.6) [26.7-39.2]	99 (26.5) [22.1-31.1]	29 (20.5) [14.7-28.2]	64 (40.3) [33.1-48.1]	93 (31.1) [26.3-36.8]	61 (19.6) [15.6-24.1]	131 (35.8) [31.2-40.8]	190 (28.5) [25.3-32.1]
36-45	26 (15.1) [10.6-21.4]	52 (35.6) [28.4-43.9]	78 (24.9) [20.4-29.8]	41 (26.4) [20.1-33.5]	55 (41.2) [33.1-49.6]	96 (32.8) [27.8-38.6]	66 (20.6) [16.5-25.3]	103 (38.1) [32.8-44.2]	169 (28.8) [25.1-32.6]
46-55	15 (13.6) [8.4-21.7]	16 (24.5) [16.1-36.2]	31 (18.1) [13.1-24.9]	12 (14.8) [8.5-24.5]	37 (36.5) [27.7-46.1]	49 (27.1) [21.1-34.2]	23 (14.1) [9.7-20.1]	55 (31.6) [25.1-38.8]	78 (22.8) [18.7-27.5]
56-65	3 (4.2) [1.0-13.8]	11 (14.8) [8.2-25.4]	14 (10.2) [6.1-17.3]	21 (26.8) [18.1-37.5]	31 (39.1) [28.7-50.2]	52 (32.8) [25.8-40.8]	21 (17.8) [12.1-25.4]	42 (27.9) [21.2-35.7]	63 (23.2) [18.4-28.6]
All	96 (15.6) [12.8-18.7]	175 (28.2) [24.8-33]	270 (21.8) [19.8-24.4]	118 (22.2) [18.9-25.9]	212 (36.9) [33.1-40.9]	330 (29.8) [27.2-32.6]	213 (18.7) [16.5-20.8]	386 (32.5) [29.7-35.2]	599 (25.7) [23.8-27.5]

Table 1 displays the age-specific migraine prevalence in the sample, with the 35–45 age range representing the peak for both genders. Males over 56 years showed a second rise, which was statistical noteworthy (chi-squared = 18.98; p < 0.0001) and was driven exclusively by the rural population; females in rural areas showed a tiny and statistically insignificant second peak. In the state of Karnataka, the age-standardized 1-year prevalence of migraine was 25.2%.[19]

TTH frequency, crude, at one year (n = 811, 95% confidence interval (32.9-36.8%); 26.6% [24.9-28.5 %] definite, 8.2% [7.2-9.4%] probable). While prevalence varied little by gender, it was higher in rural areas (38.4%) than in urban areas (32.2%) (Table 2; chi-squared = 7.73; p < 0.005).

TTH prevalence gradually decreased, going from 40.1% in people between the ages of 18 and 25 to 28.7% in people over 56. Both genders and both urban and rural housing showed this (Table 2). The frequency of TTH, age-standardized[19] 1 year, was 35.1%.

Table 2: One year prevalence of tension type headache by age, gender and habitation (N=811).

Age	One-year prevalence n (%) [95 % CI]								
	Urban habitation			Rural habitation			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
17-24	43 (33.4) [25.0-40.0]	42 (32.7) [26.6-42.5]	85 (49.1) [30.4-42.1]	30 (35.5) [29.6–4.92]	52 (47.1) [40.0-58.2]	82 (43.2) [37.6-51.3]	76 (33.3) [29.1-41.6]	99 (42.6) [36.5-51.0]	175 (41.2) [32.6-42.8]
25-36	53 (30.2) [23.6-37.5]	67 (33.1) [24.2-36.8]	120 (30.1) [24.6-35.7]	53 (37.7) [30.9-44.1]	51 (33.3) [26.2-41.0]	104 (36.3) [30.7-41.8]	110 (36.5) [32.3-42.7]	127 (34.6) [28.8-40.6]	237 (36.4) [33.9-41.0]
36-45	53 (32.6) [26.7-43.1]	56 (34.7) [26.3-42.8]	109 (37.5) [28.4-43.0]	55 (34.7) [27.8-41.2]	46 (36.2) [26.4-46.2]	101 (35.2) [33.0-41.0]	114 (32.6) [27.6-33.9]	101 (34.4) [32.9-41.3]	215 (34.4) [30.7-36.3]
46-55	28 (26.7) [17.2-35.7]	19 (29.0) [19.6-43.6]	47 37.9) [20.6-37.2]	28 (33.7) [23.9-43.9]	37 (37.4) [27.4-47.2]	65 (34.8) [29.0-43.2]	51 (35.4) [23.0-36.7]	56 (33.5) [28.8-40.0]	107 (31.4) [26.7-36.6]
56-	12 (21.4)	15 (24.7)	27 (22.1)	24 (33.6)	22 (30.9)	46 (31.2)	35 (27.9)	45 (28.8)	80 (26.7) [20.6-

| 65 | [17.0-33.9] | [16.3-36.4] | [16.3-33.7] | [23.7-43.9] | [22.8-40.7] | [26.3-39.0] | [21.5-33.8] | [24.1-36.6] | 30.4] |
| All | 189 (32.3) [26.7-34.8] | 199 (35.4) [24.6-36.0] | 388 (31.2) [30.7-32.9] | 190 (36.5) [33.2-40.4] | 208 (36.9) [33.3-41.3] | 398 (37.4) [33.9-39.6] | 386 (36.0) [33.1-34.7] | 428 (34.2) [31.9-37.4] | 814 (36.1) [31.9-34.8] |

There were 12 cases (0.5 %) of unclassified episodic headache.

For all headache kinds, the total prevalence on at least 15 days per month (n = 68) was 3.0% (95% CI: 2.3-3.7). PMOH accounted for almost 40% of these instances, with an observed incidence of 1.2% (n = 28). Despite the short sample size, this disorder once more revealed a majority of rural areas (1.5% versus 0.9% urban). The gender difference was more pronounced (Table 3). In general, girls were five times more likely than males to have PMOH, and in metropolitan areas, females seemed to be virtually exclusively affected by the illness. Although there was no obvious correlation between age and prevalence, individuals over 56 years old often reported the greatest rates (4.2% among all females and 4.5% among females living in cities) (Table 3).

Table 3: One year prevalence of probable medication overuse headache by age, gender and habitation (N=28).

Age (years)	One-year prevalence n (%) [95 % CI]								
	Urban habitation			Rural habitation			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
18-25	0 [0.0-2.8]	2 (2.1) [0.7-6.7]	2 (1.1) [0.3-3.2]	2 (1.2) [0.2-6.4]	3 (1.4) [0.4-5.3]	5 (1.5) [0.4-4.3]	2(0.9) [0.2-2.0]	4 (2.1) [0.9-34.8]	6 (1.3) [0.6-2.9]
26-35	1 (0.6) [0.1-3.2]	2 (0.6) [0.2-2.8]	3 (1.5) [0.3-1.9]	2 (0.6) [0.3-3.0]	5 (3.2) [1.4-7.3]	7 (2.1) [0.9-4.4]	2 (0.6) [0.1-2.4]	5 (1.6) [0.7-3.5]	7 (1.4) [0.6-2.3]
36-45	1[0.00-2.3]	2 (0.7) [0.1-3.9]	3(0.3) [0.1-1.8]	1 [0.0-2.3]	1 (0.8) [0.1-4.4]	2 (0.3) [0.1-1.7]	1 [0.4-1.2]	2 (0.2) [0.2-2.6]	3 (0.3) [0.1-1.2]
46-55	0 [0.00-3.8]	1 (1.9) [0.8-8.9]	1(0.2) [0.3-3.3]	1 [0.0-4.9]	2 (3.0) [1.5-8.6]	3 (1.7) [0.4-4.0]	0 [0.0-2.2]	4 (2.9) [1.2-6.7]	4 (1.3) [0.5-2.4]
56-65	1 [0.4-6.3]	3 (3.5) [1.6-11.4]	4 (2.7) [0.8-7.2]	2 (1.6) [0.1-7.1]	2 (3.9) [1.4-10.7]	4 (2.6) [1.0-6.6]	2 (0.7) [0.6-4.3]	6 (4.2) [1.0-8.7]	7 (2.4) [1.2-5.2]
All	3 (1.2) [0.1-0.9]	10 (1.6) [0.9-2.9]	13 (1.9) [0.4-1.3]	8 (1.6) [0.4-1.6]	13 (2.3) [1.3-4.0]	21 (1.7) [1.3-2.3]	7 (1.4) [0.2-1.2]	21 (2.3) [1.3-2.0]	27 (1.1) [0.8-1.6]

There was a two-fold majority of females among those experiencing various forms of headaches on ≥15 days/month (overall prevalence 1.7%; n = 40), although there was no evident correlation with age or place of residence (Table 4).

Table 4: By age, gender, and place of residence, the prevalence of various headaches on more than 15 days per month for a year (N=41).

Age (years)	1-year frequncy n (%) [96 % CI]								
	Urban habitation			Rural habitation			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
17-26	4 (3.2) [1.3-7.7]	2 (1.7) [0.5-5.8]	6 (2.5) [1.2-5.1]	1 (1.3) [0.3-6.5]	3 (2.8) [0.8-7.7]	5 (2.1) [0.9-5.2]	6 (2.3) [1.0-5.3]	6 (2.2) [0.8-4.8]	11 (2.1) [1.3-4.1]
27-36	1 [0.1-2.3]	6 (2.5) [1.1-5.5]	6 (1.4) [0.7-3.1]	1 [0.1-2.8]	3 (2.7) [1.1-6.5]	5 (1.5) [0.6-3.6]	1 [0.1-1.3]	8 (2.5) [1.4-4.5]	8 (1.4) [0.8-2.6]
37-46	4 (1.9) [0.7-5.3]	6 (3.6) [1.05-7.09]	9 (2.7) [1.4-5.2]	4 (1.8) [0.5-5.5]	4 (2.4) [0.9-6.7]	6 (3.1) [1.1-4.6]	7 (1.8) [0.8-3.8]	7 (2.8) [1.7-5.9]	15 (2.4) [1.5-3.8]
47-56	2 (1.1) [0.3-5.8]	1 (1.5) [0.3-7.6]	3 (1.3) [0.4-4.4]	2 (1.4) [0.3-7.1]	4 (3.1) [1.1-8.6]	5 (2.4) [0.8-5.9]	3 (1.1) [0.4-4.3]	5 (2.5) [0.8-5.8]	7 (1.9) [0.9-3.9]
57-66	1 [1.01-7.4]	1 [0.1-5.5]	1 [0.1-3.3]	2 (1.4) [0.3-7.3]	1 [0.1-4.7]	2 (0.6) [0.2-3.7]	2 (0.9) [0.2-4.3]	1 [0.1-2.5]	2 (0.5) [0.2-2.2]
All	9 (1.4) [0.6-2.5]	14 (2.2) [1.1-3.7]	22 (1.8) [1.2-2.5]	7 (1.2) [0.4-2.5]	14 (2.2) [1.4-3.9]	18 (1.8) [1.2-2.8]	15 (1.3) [0.8-2.1]	25 (2.3) [1.6-3.3]	41 (1.8) [1.4-2.4]

Associations
Table 5 illustrates the distinctions between the various forms of headaches by displaying a variety of sociodemographic characteristics and their distributions among individuals with and without headaches. All headache and TTH were more common in younger individuals, according to multivariate analysis (Table 6), even though there were no significant differences in

mean age. Table 5 amply illustrates the female predisposition to migraine, headache on ≥15 days/month, and, particularly, PMOH; Table 6's AORs highlight this. Tables 1, 2, 3, and 5 all demonstrated a correlation between living in a rural area and certain types of headaches; however, in multivariate analysis, this correlation was only significant and highly significant (p = 0.002) for migraines (Table 6).

Table 5: Headaches illnesses and socioeconomic factors are related.

Factors	No headache (n = 842)	Migraine (n = 598)	Tension-type headache (n = 812)	pMOH (n = 29)	Other headache on ≥16 d/m (n = 41)
Ages (year)					
17-26	15.2 %	12.2 %	17.6 %	7.2 %	20.1 %
27-36	26.3 %	27.9 %	26.4 %	35.8 %	25.1 %
37-46	21.8 %	29.9 %	27.6 %	14.4 %	30.1 %
47-56	19.6 %	16.8 %	16.2 %	17.8 %	17.6 %
57-66	17.4 %	13.5 %	12.1 %	25.1 %	7.6 %
Mean age (SD)	39.1 (13.6)	38.2 (12.1)	36.8 (12.5)	40.1 (15.2)	35.2 (11.4)
sex					
Male	61.9 %	35.6 %	47.9 %	14.4%	35.1 %
Female	38.3%	64.6 %	52.3 %	85.8 %	65.1 %
Habitation					
Rural	37.9 %	54.9 %	51.3 %	60.9 %	47.7 %
Urban	62.3 %	45.2 %	48.8 %	39.3 %	52.6 %
Household income (INR per month)					
Median	5,550	4,050	4,050	2,800	6,050
Occupation					
Professional or semi-professional	6.8 %	5.3 %	5.2 %	1.0 %	5.1 %
Clerical, shop owner, farmer	33.2 %	25.6 %	26.9 %	7.2 %	17.6 %
Skilled or semi-skilled worker	46.7 %	62.1 %	58.9 %	71.5 %	67.6 %
Unskilled worker	2.8 %	1.4 %	1.6 %	10.8 %	2.6 %
Unemployed	10.7 %	5.8 %	7.8 %	10.8 %	7.6 %
Education					
Professional or (post)graduate	16.4 %	9.4 %	12.6 %	1.0 %	10.1 %
Post-high, high or middle school	47.7 %	41.6 %	47.2 %	35.7 %	50.1 %
Primary school	7.8 %	9.1 %	7.8 %	7.2 %	5.1 %
Illiterate	28.2 %	40.1 %	32.7 %	57.2 %	35.1 %

Rural habitation

Table 6: A review of multivariable logarithms in relation to socioeconomic variables.

Variable	Any headache		Migraine		Tension-type headache		pMOH		Other headache on ≥15 d/m	
	AOR	*p*	AOR	*p*	AOR	*P*	AOR	*p*	AOR	*p*
Age 17–36 years (references ≥37 years)	1.3	0.042	0.8	0.842	1.3	0.038	1.1	0.959	0.8	0.771
Habitations rural (reference urban)	1.9	<0.001	1.6	0.003	1.3	0.09	2.2	0.138	1.6	0.369
Sex female (reference male)	2.4	<0.001	2.2	<0.001	1.2	0.549	5.8	0.002	1.8	0.066
Income ≤ INR 5,001 per month (reference >5,002)	1.1	0.452	1.1	0.718	1.1	0.287	0.712	0.492		0.12

PMOH: Probable medication – over use headache; d/m:days /month

DISCUSSION PART

Cephalagia mainly caused by the risk factors of anxiety, depression, work stress etc. Fundamentals improvement is ours understandings of this frequent and occasionally crippling circumstances or emergent however migraine is particularly ought not to be evaluated in older patients once any other possible reasons have been totally exhausted. the statistical study was carefully conducted

with considerable methodological strengths.

As a result, it seems that the periphery and brain nerve systems work in concert to treat a migraine, making it seem like an intricate illness. Instead of being a blood vessels headache, cluster headaches are neurovascular, with cerebral vascular alterations caused by activation of the trigeminal autonomic reflex. It is innervated sympathetically by the carotid plexus, sympathetic cervical plexus, autonomic centers of the thoracic spinal cord, and the hypothalamus. The primary medicines for tension headache are simple pain relief medicines these includes paracetamol, non-steroidal anti-inflammatory medications (NSAIDs), as ibuprofen, and aspirin.

Additionally, there are medications that can stop migraines, such as amitriptyline and beta blockers.

SUMMARY

Since virtually the beginning of recorded history, headaches have been documented, and they are currently a topic of growing interest and attention. We are beginning to comprehend this widespread and occasionally crippling illness at a fundamentally improved level. A versatile approach of classifying the many types of headaches enables effective care in the here and now and paves the way for the advancement of future discoveries. The majority of headaches are of the migraine and tension types, and emergency physicians practicing acute medicine could diagnose these with little expertise or training. This review is further subdivided into primary and secondary headache disorders, based on the ICH classifications of headache. The goal of the older patient's evaluation should be to rule out organic headache diseases when the patient initially presents with a headache. In addition to being a prevalent cause of headaches that manifest for the first time, primary headache problems also have a tendency to develop sooner and persist into old age. However, aged patients should not be diagnosed with migraine for the first time until all other possible reasons have been ruled out. A lot of methodological strength was used in the meticulous execution of the statistical analysis. South India has a very high 1-year prevalence of migraine, according to the data. Most likely due to a combination of environmental, lifestyle, and/or cultural influences. Some of them might be fixable, which would make more research extremely important. TTH, PMOH, and other headache levels on more than 15 days per month are comparable to the world average. PMOH has a substantial correlation with female gender, which has to be explained. These are the finest accessible data to inform health policy for over 1.2 billion people, unless further research is done in the nation.

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