Headache is one of the most universally experienced ailments; it is rare for a person to have never experienced one. However, certain forms of headache in children, such as migraine, impose not only significant disability due to prolonged periods of pain and school absenteeism, but affect quality of life for the entire family. This issue of Pediatric Annals is dedicated to understanding the common and not so common causes of headache in childhood. As practicing clinicians, we must uncover the cause of headache, initiate an appropriate acute or preventive treatment regimen, counsel the family regarding lifestyle changes, and be aware of situations that require referral for in-depth investigations—all in a relatively brief clinic visit.

The symptoms of migraine in childhood can vary significantly from migraine in adults. Knowledge of common migraine precursors and variants, such as paroxysmal torticollis and abdominal migraine in younger children, and unique conditions, such as acute confusional migraine in teenagers, can help the astute clinician make the appropriate diagnosis in the outpatient setting. Dr. A. David Rothner, a renowned expert in the field of childhood headache from the Cleveland Clinic, reviews periodic syndromes specific to childhood in the article “Migraine Variants in Childhood.”

Drs. Marina Khrizman and Ann Pakalnis review treatment options for migraine in the article “Management of Pediatric Migraine: Current Therapies.” Although most drug trials for migraine were conducted in adults, we fortunately now have considerable data to make treatment recommendations for acute migraine in the pediatric age group. Ambiguity still exists regarding how to treat children with chronic migraine as evidenced by The Childhood and Adolescent Migraine Prevention study. It is not clear if treatment with a prescription drug is significantly better for a patient with chronic migraine compared to a placebo. Nonetheless, several prophylactic drug options, including natural supplements that can be initiated by the pediatrician are discussed in this article.

Concussion and the sequelae of concussion continue to be major public health concerns. Primary care physicians are often on the front line of queries regarding management of postconcussion syndrome and post-concussion headaches. Drs. Raquel Langdon and Sharief Taraman have elaborated on recognition of post-concussion headache, evaluation, and therapeutic strategies in the article “Posttraumatic Headache.” Recent changes in treatment paradigms with respect to “brain rest” are addressed and may be of practical value to primary care physicians who counsel young athletes.

A child with unusual headache symptoms evokes academic curiosity regarding the underlying diagnosis but also discomfort for fear of missing a serious underlying neurologic disease. Dr. M. Cristina Victorio outlines some “red herrings” in headache medicine in the article “Uncommon Pediatric Primary Headache Disorders.” Recognizing an infrequent constellation of clinical features can be gratifying to the clinician and save the family a visit to the emergency department or a neurologist. Some of these disorders can be quickly diagnosed by a direct history or a photograph of the child during the episode. Specific treatment options exist in most instances.

The final article, “Life-Threatening Headaches in Children: Clinical Approach and Therapeutic Options” by Drs. Nagma Dalvi and Lalitha Sivaswamy, discusses the symptoms and signs of neurological disorders that, if left unrecognized, can lead to death or marked disability in the form of stroke or blindness. In most cases, associated neurological signs can guide the clinician toward the correct imaging modality. Recognition of these signs requires only a detailed bedside neurological examination and knowledge of certain “red flags.”

We hope this issue provides a framework for thoughtful manage-
ment, referrals, investigations, and treatments for pediatric headache concerns; most importantly, we hope that pediatric clinicians have gained some tools to reassure patients and their families that there are no underlying brain disorders if that is indeed the case.

REFERENCES

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