International Classification of Headache Disorders, 3rd Edition: What the Pediatrician Needs to Know!

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Headache is a common problem in children and causes significant disability [1]. Robust diagnostic criteria are essential due to its high prevalence and the absence of any diagnostic investigations. The International Classification of Headache Disorders, 3rd edition (ICHD-3) has been released by the 'International Headache Society' in May 2013 [2]. As this version is based on a large body of research on headache, in contrast to previous editions that were mostly based on opinion of experts, it is being considered as a major step forward in the diagnosis and management of headache [3]. We herein present the salient features of the new classification, which are likely to be of interest to the pediatricians. The important ones include change in some terminologies, addition of new categories and changes in diagnostic criteria, and have been summarized in ***Table* I**.

The most important change has been in the diagnosis of 'Secondary' headaches, which will be of interest to those in developing countries because of the high numbers of such headaches [4,5]. When a new headache occurs in close temporal relation to another disorder that is known to cause headache (or fulfills other criteria for causation by that disorder), it is coded as Secondary headache, attributed to the causative disorder even if the headache has the characteristics of a Primary headache (migraine, tension-type headache, etc.) [3]. ICHD-2 required 'remission or substantial improvement of the underlying causative disorder' before the diagnosis of Secondary headache could be made [6]. The new diagnostic criteria can thus be applied at presentation, or as soon after as the underlying disorder is confirmed. In acute conditions, a close temporal relation between onset of headache and onset of the presumed causative disorder is often sufficient to establish causation, whereas less acute conditions usually require more evidence of causation.

The other important change is in the category 'Childhood periodic syndromes that are commonly precursors of migraine' (benign paroxysmal vertigo of childhood, cyclical vomiting and abdominal migraine) [6] that have now been renamed as 'Episodic syndromes that may be associated with migraine', and have an additional condition Benign paroxysmal torticollis. Cyclical vomiting and Abdominal migraine have been clubbed together as 'Recurrent gastrointestinal disturbance' [2].

The changes in ICHD-3 have been presented here in an abridged form. Those interested in a more detailed study of these guidelines may see the full document or visit the International Headache Society website for further information (*www.ihs-headache.org*).

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TABLE I SELECTED CHANGES IN ICHD 3 FROM ICHD 2*

ICHD II	*ICHD III*	*Remarks*
New terminology		
Childhood periodic syndromes	Episodic syndromes that may be associated with migraine	May also occur in adults.
Basilar-type migraine	Migraine with brainstem aura	Involvement of the basilar artery is unproven.
Cluster headache and other Trigeminal autonomic cephalalgias	Trigeminal autonomic cephalalgias	
New entities		
–	Headache attributed to aeroplane travel	Headache occurring during airplane travel and remitting after landing.
–	Benign paroxysmal torticollis	Recurrent episodes of one-sided head tilt with slight rotation, with onset in the first year.
Changes in classification		
Vomiting syndrome and Abdominal migraine	*Grouped as*: Recurrent gastrointestinal disturbance	
Simple analgesic-overuse headache	Sub classified in to Paracetamol (acetaminophen)-overuse, Acetylsalicylic acid-overuse and Other NSAID-overuse headache	As analgesic-overuse headache is a common entity, and can be caused by a variety of analgesics, separate coding has been provided.
Familial hemiplegic migraine (FHM)	Sub-classified in to specific genetic subtypes	According to gene mutation *viz.* FHM Type 1 to 4.
Changes in diagnostic criteria		
Abdominal migraine and Migraine without aura: For children (<18 yrs) the duration of attack should be ≥1 h	Changed to more than two hours	Not enough evidence to suggest attacks with duration <2 h in children
Benign paroxysmal vertigo	Additional criteria added: "at least one of the following: nystagmus, ataxia, vomiting, pallor and fearfulness"	Parental observation of episodic periods of unsteadiness may be interpreted as vertigo in young children.
Headache induced by food and/or additive: 'ingestion of a minimum dose required	Minimum dose no longer required	Making diagnosis more feasible.
Post-dural puncture headache: Spontaneous remission ≤1 wk	Within 2 weeks	

**Prepared using material provided in ICHD-2 and ICHD-3 documents of International Headache Society [2,6]. The descriptions provided here are not the full diagnostic criteria for many of the conditions. Please refer to the original document for the same.*