Post Covid and Post Covid vaccine headache

For the purposes of long-term management, both are treated similarly, having excluded a thrombotic episode with vaccination. The cause of headache in both cases is unknown but increased CGRP, interleukins and TNF alpha have been implicated and the mechanism is probably similar in both.

- The position with medication over use headache is unclear but it should be borne in mind.
- Invariably there are other clinical features and in particular lethargy.
- Pain most commonly bilateral and mild to moderate.
- Headache can present as the first symptom in Covid and is a feature of 10 to 30% of those hospitalised.
- Headache is more treatment resistant.
- The situation is complicated by the significant incidence of headache in a non-Covid population and the conflicting factors of anxiety, social isolation and the wearing of masks.

Management

- Exclude thrombotic Post Covid Immunisation headache.
    - Time of concern 4-30 days.
    - Of concern - new-onset severe and persistent headache, thunderclap headache, headache worse on lying, blurred vision, confusion, seizures, shortness of breath, chest pain, leg swelling, persistent abdominal pain, unusual skin bruising or pinpoint spots beyond the injection site.
    - Urgent platelets and d dimer and possible imaging.
    - Watch risk factors – Pregnancy, vasculitis, thrombophilia, systemic infections, trauma, malignancy, obesity, thyroid disease, inflammatory bowel disease.

If thrombosis has been excluded, treat as post-viral headache as below.

- Treat to the nearest headache type. E.g., is there nausea, light sensitivity when bad? If so, treat as migraine. Any primary headache can present. There may be a phenotype predisposition. (e.g. family history of migraine, past history of a primary headache).
- It has been suggested that in some cases the CSF pressure is re-set to a slightly higher level. Check head down tilt for sub-clinical raised CSF pressure. Seek advice if this is positive.
- Look out for red flags. Secondary pathology can always develop co-incidentally.
- Other off license treatments that have been used but not supported by an evidence base include:
    - Steroids. 1mg/kg max 60mg 3 days and reduce over three weeks.
    - Drugs with anti-viral properties. Long-term famciclovir 250mg BD, Celecoxib mg 200 BD. Can be used in combination.
    - Anti-inflammatory/Immune modulation. Montelukast 20mg OD for two weeks and then 10mg OD but caution neuropsychiatric side effects and Doxycycline 100mg OD have been used.
    - High dose Co Q10 (up to 600mg/day) has been used for associated lethargy.