

## NEUROLOGY WAIVERS

CONDITION: HEADACHE (ICD9 784.0)

Revised February 2002

**AEROMEDICAL CONCERNS:** Headaches are common and estimated to affect over 70% of Americans. Occasional headaches, responding to simple analgesics, are not a major aeromedical concern and do not require extensive evaluation. Severe headaches can be incapacitating in flight while milder headaches will act as a distraction. Cluster headaches are incapacitating and may be associated with transient neurologic symptoms, rhinorrhea, lacrimation and a unilateral Horner's syndrome. (See also Migraine APL) Two main questions must be answered with regard to aeromedical evaluation of headaches:

- 1) Are the headaches primary or secondary to an underlying condition?
- 2) Are the headaches chronic, recurrent, and /or of sufficient severity to pose a risk to flight safety?

### **WAIVER:**

Initial Applicants (All Classes) & Rated Aviation Personnel: The aeromedical disposition of members with headache will depend on the frequency and severity of the symptoms, the etiology, and the medication required to control the headaches.

The specific nomenclature or diagnostic label of the headaches is not the key factor for determining fitness for aviation duty. Of greater concern is the effect on general performance, special senses, and the risk of recurrence.

ICD9 Code	Condition
346.2	Cluster headache
307.81	Tension headache

### **INFORMATION REQUIRED:**

- Neurology consultation,
- AMS listing the timing, duration, frequency, triggers, and predictability of episodes,
- FDME- complete physical examination to rule out secondary causes; and,
- Brain imaging- contrast-enhanced CT or MRI to evaluate for structural disease when indicated by history or examination

**FOLLOW-UP:** Follow-up is dictated by the frequency or severity of the headache as well as the response to therapy. If symptoms warrant, an annual neurology or internal medicine consultation may be required.

**TREATMENT:** Simple analgesics are acceptable. The chronic use of NSAIDs may be considered for waiver. Life-style changes, biofeedback and relaxation therapy, if

successful, may permit return to flight status for the muscle-contraction or "tension" headache sufferer. Psychiatric/psychologic evaluation of these members is strongly recommended. Treatments for cluster headaches that are effective but not compatible with flight training include lithium, methysergide, intranasal lidocaine, adrenocorticosteroids, and oxygen inhalation. Sumatriptan or other 5HT serotonin receptor agonists may be used but require a 12-hour mandatory grounding period following use; frequency of its use should be carefully evaluated by the local FS. Frequent use of medications in this class may reflect vascular or migraine headaches. Verapamil may be an effective prophylactic treatment for cluster or vascular headaches in some cases. Use of verapamil must be waived for rated aviation personnel and waivers for this will be considered on a case-by-case basis.

**DISCUSSION:** Cluster headaches occur almost exclusively in men, begin in the third or fourth decade, are unilateral and never change sides. Clusters consist of recurrent headaches lasting about 45 minutes, several times a day and night for a few weeks to months at a time with a tendency to recur annually, often around the summer or winter solstice. Recurrence patterns may be characteristic for an individual, but may vary considerably between sufferers. Recurrent muscle-contraction or tension headaches are normally associated with some psychosocial stress in the majority of cases; however, underlying cervical spondylosis and DJD may be a contributing factor and will respond to NSAIDs and physical therapy. Exertional headaches, cough headaches and immersion headaches may be associated with posterior fossa pathology (especially Arnold-Chiari Malformation) warranting an MRI scan. Coital headaches are almost always benign, but are sometimes associated with subarachnoid hemorrhage and should be evaluated with CT with and without contrast, MRI, and possibly even Lumbar Puncture (LP). Incorrect prescription for astigmatism may be a cause for headache. In general, however, eye and ENT pathologic explanations for headache are unlikely unless the patient has obvious gross clinical findings of disease in these areas.

**REFERENCE:** American Academy of Neurology, *Multispecialty Consensus on Diagnosis and Treatment of Headache*, "Headache Guidelines."  
[www.aan.com/public/practiceguidelines/](http://www.aan.com/public/practiceguidelines/)