



A Child Presenting With Headache and Periorbital Bruising

Baş ağrısı ve Periorbital Morarma ile Başvuran Çocuk
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Abstract

This study aimed to introduce a patient with a rarely encountered case of recurrent dark discoloration. A 12-year old girl with headache that started 2 weeks ago was admitted to our clinic. In that time, the complaint of rash followed by darkening and bruising around both eyes has developed. When her headache relief, the bruising disappears. She has a symptom of nausea but does not vomit. She has applied to emergency service 5 times in two weeks for dark discoloration. She had no history of hospitalization. Her uncle has a history of migraine. There was no consanguineous marriage between parents. There was no headache localization, she feels the pain all over her head and it lasts for a whole day. There was no history of alcohol or drug abuse. Her headache was not triggered by any food or drink. When the bruising occurs, her vision becomes blurry. She has photophobia and phonophobia. She cannot sleep because of her headache and sleeplessness increases her complaints. She has missed several days of school. She spends too much time on phone and computer. She has stress and crying spells. Her neurological examination is normal. Fundus examination is natural and there is no papilledema. She does not have opsoclonus, myoclonus or nystagmus. The EEG, brain MRI and MRI venography are normal. She does not have anemia and the labs are normal. Pseudotumor cerebri, neuroblastoma or allergic reaction was not considered. Propranolol and fluoxetine were commenced for migraine prophylactic treatment and the patient's headache improved. And she is still followed-up. Co-occurrence of dark discoloration and headache are reported with trigeminal autonomic cephalgia, neuroblastoma, sinus vein thrombosis, idiopathic intracranial hypertension, amyloidosis and aplastic anemia in the literature. However, these recurrent symptoms are predominantly associated with migraine.

Keywords: Dark discoloration; headache; migraine.

Özet

Bu sunumda rekürren gözlerde morarma ve baş ağrısı olan nadir bir olguyu sunmayı amaçladık. Oniki yaşındaki kız hastada 2 hafta önce baş ağrısı başlamış. Ağrısı olunca her iki göz çevresinde önce kızarıklık, takibinde koyulaşma ve sonrasında morarıp siyahlaşma oluyor. Ağrısı hafifleyince gözlerdeki morluk kayboluyor. Bulantısı var, kusma yok. Ailede migren öyküsü amcada mevcut. Akrabalık ve hastanede yatış öyküsü yok. 2 hafta içinde 5 kez göz çevresinde morarma olmuş ve acile başvurmuş. Ağrının lokalizasyonu yok, başının her yerinde hissediyor ve tüm gün sürüyor. İçki veya madde kullanım öyküsü yok. Yiyecek veya içeceklerle tetiklenmiyor. Gözleri morardığında görmeye bulanıklık oluyor. Fotofobi ve fonofobi var. Ağrı yüzünden uyuyamıyor ve uykusuzlukla semptomları artıyor. Okul gün kaybı mevcut. Çok telefon ve bilgisayar kullanıyor. Stres ve ağlama atakları oluyor. Nörolojik muayene normal. Fundus muayenesi doğal papil ödemi yok. Opsoklonus, myoklonus, nistagmus yok. EEG, beyinMR ve MRvenografi normal. Anemi yok, biyokimyasal parametreler normal. Psödotümörserebri, Nöroblastom ve allerik reaksiyon düşünülmüdü. Hastaya propranolol ve fluoksetin migren profilaksisi başlandı. Takibinde ağrıları gerileyen hastanın izlemi sürüyor. Literatürde gözlerde morarma ve baş ağrısı birlikteliği Trigeminalotonomiksefalji, nöroblastom, sinus ventrombozu, idiyopatik intrakranial hipertansiyon, amiloidoz ve aplastik anemi ile bildirilmiştir. Bu rekürren semptomlar daha çok migren kliniğini düşündürmektedir.

Anahtar Kelimeler: Periorbital morarma; baş ağrısı; migren.

Introduction

Childhood headaches are a cause of concern for both families and physicians as they may be the symptoms of a wide range of diseases ranging from simple viral infections to brain tumors. Some structures outside the head such as skin, subcutaneous tissues, muscles, mucosa, large veins, teeth, and large veins, vascular sinuses inside the head, dura and brain

arteries surrounding these comprise of the “pain-sensitive” areas in the head. “A global campaign against headache worldwide to reduce the burden of headache” was initiated. The first data obtained by collecting 107 epidemiological studies around the world have been published. According to the results of these studies in which 6 studies from Turkey were included, the prevalence of recurrent headache worldwide was found 46% in adults and

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51% in children. The prevalence of migraine was reported as 11% in adults and 7% in children. While males are more commonly affected by headache compared to females before puberty, it becomes more common in females with puberty (1). Recent studies have revealed that the prevalence of headache, migraine and tension-type headache (TTH) has significantly increased in general compared to 10-20 years ago (2,3,4). Migraine is a common example of acute recurrent and throbbing headache varying in intensity and frequency and accompanied by nausea, vomiting, photophobia and/or phonophobia. Although migraine-type headache is common in children and teenagers, mostly it is easily associated with other causes such as sinusitis or stress but is not considered as a differential diagnosis. Headaches accompanied by cranial autonomic symptoms are classified under the subtitle of trigeminal autonomic headaches [short-lasting unilateral neuralgiform headache attacks (SUNCT), paroxysmal hemicranias with cluster headache, red and watery eyes] among primary headaches (6). It is known that cranial autonomic symptoms may also be seen during migraine attacks (7,8). It was stated in recent researches that cranial autonomic symptoms (watery and red eyes, droopy eyelids, miosis, stuffy or runny nose, forehead or facial sweating) were seen in 27-73% of the patients during migraine attacks (9,10,11).

Case

Informed written consent was obtained from the patient's parent, both for the presentation and for the use of the photographs. We shared the follow-up of a female child with autonomic symptoms of apparent bruising around eyes and getting back to normal when the pain disappeared. A 12-year old girl with headache that started 2 weeks ago was admitted to our clinic. In that time, the complaint of rash followed by darkening and bruising around both eyes has developed. When her headache relief, the bruising disappears (Fig 3). She has a symptom of nausea but does not vomit. She has applied to emergency service five times in two weeks for dark discoloration. She had no history of hospitalization. Her uncle has a history of migraine. There was no consanguineous marriage between parents. There was no headache localization, she feels the pain all over her head. The pain does not stop with paracetamol she takes at home. No history of alcohol or drug abuse. Her headache was not triggered by any food or drink. When the bruising occurs her vision becomes blurry. She has photophobia and phonophobia. She cannot sleep because of her headache and

sleeplessness increases her complaints. She has missed several days of school. She spends too much time on phone and computer. She has stress and crying spells. The patient is conscious. Cranial nerve examination is normal. The patient's coordination and gait are normal. Fundus examination is natural and there is no papilledema. There are no signs of neurocutaneous syndromes that may be associated with intracranial tumors such as neurofibromatosis or tuberous sclerosis. The patient has motion sickness. She does not have opsoclonus, myoclonus or nystagmus. The EEG, brain MRI and MRI venography are normal. She does not have anemia and the labs are normal. Pseudotumor cerebri, neuroblastoma or allergic reactions were not considered. Propranolol and fluoxetine were commenced for migraine prophylactic treatment and the patient's headache improved. She is still followed-up.

Discussion

The assessment of a child with headache is initiated with obtaining a detailed history and a detailed physical and neurological examination of the patient and generally ends up at this stage. It is crucial to understand the time pattern for pain and each type of the course has specific differential diagnoses. Questioning the frequency and duration allows defining the characteristic feature of a headache attack. For example, while the pain lasting 4 hours once a week is associated with migraine or TTH, short attacks lasting less than 5-15 minutes for several times in a day are associated with trigeminal autonomic headaches (cluster headache or paroxysmal hemicranias) or primary stinging headaches (3). Our patient's pain can be associated with migraine at first sight as it lasts more than 4 hours, is not observed every day, appears as attacks and is accompanied by photophobia and phonophobia. Autonomic symptoms are seen more in cluster and trigeminal autonomic headaches. And it is known that cranial autonomic symptoms such as watery and red eyes, droopy eyelids, miosis, stuffy or runny nose, the forehead or facial sweating) are seen during migraine attacks. When headache and bruising around the eyes are searched in literature periorbital ecchymosis and traumatic lesions are often found. When dark discoloration is searched non-traumatic case reports are found. And cases with amyloidosis and It is known that avoidance factors causing headache and most of the changes in lifestyle such as regular sleep routine, exercise and a proper diet are sufficient alone to cope with headache in children (12). In addition to these, there are some studies revealing that various

relaxation and cognitive behavior therapies are effective in reducing headaches in children (13). Acute treatment aims to stop headache in a short time. In acute treatment, ibuprofen, acetaminophen and sumatriptan nasal spray in children over the age of 12 are recommended (15). Propranolol is the first choice for treating migraine prevention if there is no contraindication. If the patient has a migraine accompanied by TTH, amitriptyline may be preferred. If the patient has epilepsy, anticonvulsants may be; if psychic problems accompany antidepressants with the cooperation of Child and Adolescent Psychiatry may be the first choice (14). We commenced 1mg/kg of propranolol as prophylaxis and 20 mg of fluoxetine with the recommendation of Child and Adolescent Psychiatry in our patient. In on-going follow-ups of the patient, no more bruising has been observed around eyes for the last 3 months (15). She sometimes has a headache and prophylaxis treatment is still applying. Co-occurrence of dark discoloration and headache are associated with trigeminal autonomic cephalgia, neuroblastoma, sinus vein thrombosis, idiopathic intracranial hypertension, amyloidosis and aplastic anemia in literature. Moreover, a detailed physical examination and imaging examinations required are very important in differential diagnosis. However, these recurrent symptoms are predominantly associated with migraine.

Conclusion

Co-occurrence of dark discoloration and headache are associated with trigeminal autonomic cephalgia, neuroblastoma, sinus vein thrombosis, idiopathic intracranial hypertension, amyloidosis and aplastic anemia in literature. Moreover, a detailed physical examination and imaging examinations when required are very important in differential diagnosis. However, these recurrent symptoms are predominantly associated with migraine.

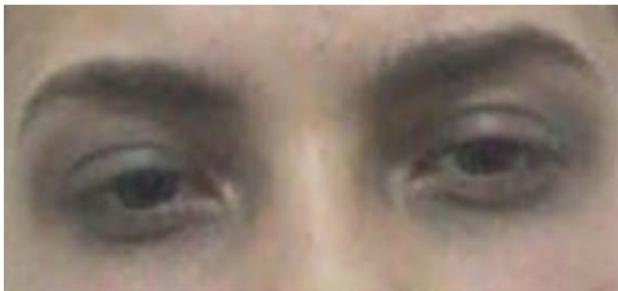


Fig. 1. The moment when the patient's headache started, at home



Fig. 2. Increase in the intensity of headache and presenting to the emergency department



Fig. 3. Getting back to normal when the headache disappears (duration of headache is 6 hours)

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