The "IHS" Classification (1988, 2004) – Contributions, Limitations and Suggestions

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Abstract
The first 'International Classification of Headache Disorders' by The International Headache Society (1988) was a major landmark document. It helped develop a common language for understanding headaches and advanced research in this neglected field. It was found to be useful, but because it was complex and cumbersome, it remained underutilised in practice. An evidence-based revised second edition was launched in 2004. This article analyses the Contributions and Limitations of this Classification. The important changes that pertain to 'Migraine' in the revised 2004 Classification have been listed. It is hoped that this Classification will be used more often in practice not only by Neurologists but by all who see headache patients in their routine practice.

Introduction
Classifications may seem complex and cumbersome but they are essential to make order out of chaos. A consistent classification system, which employs a set of scientifically derived diagnostic criteria induces comparable uniformity in clinical observations and conclusions. And so it is with headache diagnosis too!

Before early attempts at Classification, the taxonomy of headache was not uniform and there were no diagnostic criteria. In 1962, an Ad Hoc committee of the National Institutes of Health produced a classification of headache disorders which at that time represented a major step forward. Unfortunately its definitions were open to differing interpretations. At around the same time, there were rapid advances in the understanding of the biologic basis for primary headaches. So in 1985, the International Headache Society (IHS) formed a Headache Classification Committee under the Chairmanship of Prof. Jes Olesen and in 1988 published the First 'International Classification of Headache Disorders' which included specific diagnostic criteria for all headache disorders.

This Classification proved to be an enormous advance, promoted studies of the epidemiology of headache and facilitated drug trials which have formed the basis of current treatment guidelines. It withstood the test of time and was found to be particularly useful in headache research. Since the first edition was based largely upon personal opinions and general consensus, the IHS in 2004, brought out an evidence-based revision of the earlier classification and this is now popular as The International Classification of Headache Disorder 2nd Edition (ICHD-2). It provides operational diagnostic criteria for all headache types and has become the standard for headache diagnosis and clinical research. It has now been accepted by the WHO and has been used in the International Classification of Diseases 10 (ICD 10). It is imperative today, for any publication on the subject of headache to compulsorily use ICHD-2. It is therefore important for all physicians who see headache patients to become familiar with the revised classification and the criteria, as this will in future be the standard reference document for headache diagnosis, treatment and research. Unfortunately even 20 years later, most of us are still not using this Classification!

The revised 2004 Classification has 14 chapters. There are four chapters for primary headaches, eight for secondary headaches and two for cranial neuralgias, central and primary facial pain and other headache sub-types. The second edition identifies 45 primary and 120 secondary headache types and subtypes, and includes 29 causes of cranial neuralgias and central causes of facial pain. Within each group, diagnoses are arranged in a hierarchical system using upto 4 digits. In general practice, for instance, doctors can classify to the first or second digit, whereas in specialist practice, the third and sometimes the fourth digit can be used. The outline of this Classification is given below (Table 1) and the Classification is also available online at www.i-h-s.org.

Revisions in ICHD-2

There are many interesting changes in ICHD-2 (2004) and there is in addition an extensive appendix, which describes a number of disorders that need validation and proposes a few alternative criteria that can be tested. There are major additions to both Primary Headaches and Secondary Headaches. (Table 2). Some diagnoses have been moved to other sections and some others have been renamed (Table 3) reflecting changes in our perception of their underlying pathophysiology. All secondary headaches are now described as 'attributed to' instead of 'associated with'. The Appendix includes headache disorders for which there is limited evidence. It is the hope that the entities included in the appendix will be useful for future nosographic and epidemiologic research. The ICHD-2 is therefore a result of the advances in the headache field over the last two decades.

Since this is a Special issue on Migraine, this article will detail only the changes to the 'Migraine' group in the revised classification. Changes to the rest of the Classification will be beyond the scope of this article.

The Migraine group has been expanded to include many new entities. Under the types of Migraine with Aura a new entity of typical aura with non-migraine headache (1.2.2) has been added. Following recent advances in the genetics of migraine, hemiplegic migraine has now been subdivided into Familial (1.2.4) and Sporadic hemiplegic migraine (1.2.5). Basilar migraine has now been renamed basilar-type migraine (1.2.6). Amongst the childhood periodic syndromes, cyclic vomiting syndrome (1.3.1) and abdominal migraine (1.3.2) have been included while alternating hemiplegia of childhood has been moved to the appendix. In terms of duration of the headache and location of the pain, the criteria for pediatric migraine has been modified.

Under the heading complications of migraine (1.5), chronic migraine (1.5.1), persistent aura without infarction (1.5.3) and migraine – triggered seizure (1.5.5) are new inclusions. There are
Table 1: Revised IHS Classification of Headache – ICHD2 (2004)

A. Primary headache disorders

1. Migraine
   • Migraine without aura
   • Migraine with aura
     - 1.2.1 Typical aura with migraine headache
     - 1.2.2 Typical aura with non-migraine headache
     - 1.2.3 Typical aura without headache
     - 1.2.4 Familial hemiplegic migraine (FHM)
     - 1.2.5 Sporadic hemiplegic migraine
     - 1.2.6 Basilar-type migraine

2. Tension-type headache (TTH)
   2.1 Infrequent episodic tension-type headache
     - 2.1.1 Infrequent episodic tension-type headache associated with pericranial tenderness
     - 2.1.2 Infrequent episodic tension-type headache not associated with pericranial tenderness
   2.2 Frequent episodic tension-type headache
     - 2.2.1 Frequent episodic tension-type headache associated with pericranial tenderness
     - 2.2.2 Frequent episodic tension-type headache not associated with pericranial tenderness
   2.3 Chronic tension-type headache
     - 2.3.1 Chronic tension-type headache associated with pericranial tenderness
     - 2.3.2 Chronic tension-type headache not associated with pericranial tenderness

2.4 Probable tension-type headache
   • Probable infrequent episodic tension type headache
   • Probable frequent episodic tension type headache
   • Probable chronic tension-type headache

3. Cluster headache and other trigeminal autonomic cephalalgias
   3.1 Cluster headache
   • 3.1.1 Episodic cluster headache
   • 3.1.2 Chronic cluster headache
   3.2 Paroxysmal hemicrania
     • 3.2.1 Episodic paroxysmal hemicrania
     • 3.2.2 Chronic paroxysmal hemicrania (CPH)
   3.3 Short-lasting Unilateral Neuralgiform headache attacks with conjunctival injection and Tearing (SUNCT)
   3.4 Probable trigeminal autonomic cephalalgia
     • 3.4.1 Probable cluster headache
     • 3.4.2 Probable paroxysmal hemicrania
     • 3.4.3 Probable SUNCT

4. Other primary headaches
   4.1 Primary stabbing headache
   4.2 Primary cough headache
   4.3 Primary exertional headache
   4.4 Primary headache associated with sexual activity
     • 4.4.1 Preorgasmic headache
     • 4.4.2 Orgasmic headache
   4.5 Hypnic headache
   4.6 Primary thunderclap headache
   4.7 Hemicrania continua
   4.8 New daily-persistent headache (NDPH)

B. Secondary headache disorders

5. Headache attributed to head and/or neck trauma
6. Headache attributed to cranial or cervical vascular disorder
7. Headache attributed to non-vascular intracranial disorder
8. Headache attributed to a substance or its withdrawal
9. Headache attributed to infection
10. Headache attributed to disorder of homeoeostasis
11. Headache or facial pain attributed to disorder of cranium, neck, eyes, ears, nose, sinuses, teeth, mouth or other facial or cranial structures
12. Headache attributed to psychiatric disorder
13. Cranial neuralgias and central causes of facial pain
14. Other headache, cranial neuralgia central or primary facial pain.

Table 2: New additions to the ‘Migraine’ group

- Typical aura without headache [1.2.3]
- Cyclic vomiting [1.3.1]
- Abdominal migraine [1.3.2]
- Chronic migraine [1.5.1]
- Persistent aura without infarction [1.5.3]
- Migraine-triggered seizure [1.5.5]
- Probable chronic migraine [1.6.5]

Table 3: Migraine disorders which have been renamed in the new classification criteria

- Probable tension-type headache
  - Probable infrequent episodic tension type headache
  - Probable frequent episodic tension type headache
  - Probable chronic tension-type headache
- Cluster headache
  - Probable cluster headache
  - Probable paroxysmal hemicrania
  - Probable SUNCT

Contributions of the Classification

The 1988 monograph ‘Classification and Diagnostic Criteria for Headache disorders, Cranial Neuralgias and Facial Pain’ by the International Headache Society was a landmark document in the headache field. It clearly defined headache disorders and increased the interest levels in migraine and other related disorders. Vague terminologies were for the first time replaced by uniform international headache language. Clinical trials...

...some changes in the diagnostic criteria for status migrainosus (1.5.2) and migrainous infarction (1.5.4). The criteria for chronic migraine has been modified subsequently and these have been discussed in the editorial. Section 1.6 includes headaches that closely but not completely resemble migraine and are now called probable migraine instead of migrainous disorder.
were conducted using the IHS criteria and this led to rational,
evidence-based treatment strategies. The reproducibility
of epidemiologic studies on primary headaches in diverse
practice settings suggested that the criteria were generalizable.
It was therefore a positive development that contributed to a
uniform diagnostic system and led to greater focus on research
in headache.

Limitations of the Classification

No doubt, the Classification has had a major positive impact
but like with most Classifications, there are still some issues that
need debate. There has been criticism and suggestions regarding
the need for revised criteria for individual headache types. There
is not much controversy regarding the secondary headaches
but there are still issues in the primary headache category.
Some argue that the classification criteria are too detailed and
impractical for use in daily practice. Without going into the
details category-wise, one may broadly state that there are some
areas which need to be addressed in future revisions. The IHS
Classification addresses individual headache attacks only. It does
not take into account the natural history of the headache or the
spectrum of headache in the person. It does not recognise the
inter-relationship between migraine and tension-type headache.
A consistent criticism has been that the diagnostic criteria for
migraine are not applicable to children and adolescents with
migraine. For most patients with chronic daily headache the
classification is extremely challenging to use. Correspondingly,
several revised criteria have been proposed and field-tested.
There is therefore a need for future changes to address childhood
headache syndromes, chronic headaches, menstrual migraine
and headaches with overlapping features.

Suggestions for Future Classifications

The difficulty in using the Classification is largely because
of atypical episodes and recall bias. This apart, there may be a
genuine problem using the Classification at different levels of
practice in developing countries (where 80 per cent of the world
population lives !). In many areas of Asia and Africa, other
pressing health priorities confront the clinician, literacy levels
among patients are low, clinics are overcrowded and there is
less importance given to the functional quality of life. In these
settings, even neurologists might find it a dilemma to use the
Classification.

The educated proactive migrainer in developed countries,
who maintains a headache diary definitely contributes to the
ease with which doctors can use the Classification in the Western
world.

There are many additional reasons why this classification
is not easy to use in India.(4) Headache as a sub-speciality has
still not caught on. Clinics are overcrowded, there are major
problems like stroke and epilepsy that force headache medicine
into the back-seat. Not all patients are literate, recall is poor,
headache diaries are not maintained. Most clinicians find that the
classification is time consuming to use and the benefit obtained
is not proportionate as it is not a guide to specific treatment. We
need a more user-friendly version.

Conclusion

The IHS classification has contributed positively to progress
in the headache field. It is now universally employed and is
a standard document to be followed for publication in the
headache field. The present classification does have certain
drawbacks but it is only through feedback, opinions and
arguments that future editions of the Classification will be
more complete and practically relevant. So it is up to all of us
to use it and produce evidence pertaining to difficulties using
the classification. A shorter, more portable classification that
employs a more comprehensive clinic-based approach would of
course be a great improvement. But given the heterogeneity of
the headache field and the myriad clinical presentations, until
the day when we will have biological markers, I wonder if it will
be possible to have THAT perfect classification which satisfies
clinicians and researchers alike !

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