

## Managing hyperlipidaemia: a real headache

**Sir,**

Severe headache is a common presenting complaint among patients attending emergency departments. (Davenport, 2002). The predictive value of clinical history and examination alone is low (Lipton et al, 2003). Many patients therefore have invasive investigations such as lumbar puncture to exclude a sinister cause. The authors present the case of a patient who required admission and invasive investigation as a result of an atorvastatin-induced headache.

A 30-year old Caucasian man presented with a 2-hour history of sudden onset, explosive occipital headache. There was no associated meningism, nausea or collapse. He had no history of headache disorder. He had been recently commenced on atorvastatin (10 mg daily) for familial hyperlipidaemia and was on no other medications. He was apyrexial and haemodynamically stable; his Glasgow Coma Score was 15/15. Neurological examination and fundoscopy was normal. Full blood count and biochemical screen were within normal limits. Despite analgesia, the headache persisted. A computed tomography scan showed no evidence of intracranial bleeding or infarction, and no evidence of raised intracranial pressure. Lumbar puncture showed no evidence of subarachnoid haemorrhage or meningitis. He was reassured and discharged from hospital after 48 hours.

At routine follow up in the lipid clinic he reported two further episodes of severe headache post discharge. Atorvastatin was discontinued, and replaced with pravastatin 40 mg once daily. He has complained of no further headaches. In view of the normal investigations, absence of another likely cause, and the temporal relationship to commencing and subsequently discontinuing atorvastatin, it is proposed that atorvastatin was the likely cause of headache.

Severe headache presents a diagnostic challenge, and a low threshold for investigation including lumbar puncture and computed tomography or magnetic resonance imaging scanning is appropriate, although such investigations may themselves be associated with adverse effects. The statin class of lipid-lowering drugs may cause headache, and atorvastatin is particularly likely to cause adverse effects (Abourjaily et al, 2003). It is important to consider reversible causes of headache during the index admission, including a careful review of the patient's drug history.

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Abourjaily HM, Alsheikh-Ali AA, Karas RH (2003) Comparison of the frequency of adverse events in patients treated with atorvastatin or simvastatin. *Am J Cardiol* **91**: 999–1002  
Davenport R (2002) Acute headache in the emergency department. *J Neurol Neurosurg Psychiatry* **72**(Suppl II): ii33–ii37  
Lipton RB, Silberstein SD, Saper JR, Bigal ME, Goadsby PJ (2003) Why headache treatment fails. *Neurology* **60**: 1064–70

## Giving up smoking

**Sir,**

Dr Jackson's editorial on giving up smoking (vol 65(3), 2004, p. 134) is an excellent succinct account of the health hazards of tobacco smoking, the benefits of cessation and the vital role of health professionals in encouraging and helping smokers to stop.

The basics of smoking cessation advice and support are clearly listed

with the necessary emphasis on the importance of recommending the use of pharmacotherapies along with behavioural methods. The evidence of the effectiveness, albeit modest, of nicotine replacement therapy (NRT) and bupropion in achieving smoking cessation is now indisputable.

As Dr Jackson points out they are also very cost effective – about ten times more so than statins are in relation to lipid lowering. Although NRT (but not bupropion) is available over the counter and through general retail outlets, its prescription on the NHS is strongly justifiable – as the National Institute for Clinical Excellence recommends. This is especially true for smokers with established vascular disease, many of whom will be on much more expensive prescribed medication for their disease but for whom medication for smoking cessation will not have been considered.

While NRT is best avoided in a patient who has had a recent vascular event, research has not indicated that those with established vascular disease are at any greater risk from use of NRT than others. They are at considerably greater risk from their continued smoking.

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## Erratum

In the article 'Assessment and management of dysphagia' (vol 65(5), 2004, p. 274), funding support from Action Medical Research for Dr Ramsey's post should have been acknowledged.