The syndrome of persistent low cerebrospinal fluid (CSF) volume (pressure) headache is an important diagnosis for neurologists and others not to miss, because it is a treatable cause of disabling headache. It forms part of the more general diagnostic rubric of New Daily Persistent Headache (NDPH), the key feature of which is a new headache that develops over one or just a few days, and then persists (Li & Rozen 2002). This presentation should trigger a consideration of the differential diagnosis of NDPH (Table 1), particularly of treatable causes for the syndrome. Low CSF volume (pressure) headache is a very good example of this clinical phenotype.

PATHOPHYSIOLOGY
While the concept of low CSF volume (pressure) headache may seem simple enough on the surface, it has some complexities. The pain is generally considered to be due to traction on pain-producing intracranial structures – large vessels, large venous sinuses and dura mater. Indeed, Cushing, in a classic publication, noted that patients with typical low CSF volume (pressure) headache reported only unilateral headache after trigeminal root section, with ipsilateral dural anaesthesia (Cushing 1904). However, there are some unresolved issues. First, there is no clear point at which the level
(pressure)

headache
of pressure can be regarded as definitely ‘low’, because this varies between individuals. The term ‘low volume’ rather than ‘low pressure’ is therefore preferred (Mokri 1999). Absolute pressure measurements can be difficult to interpret. While low pressures, such as 0–5 cm CSF measured in the lumbar region, are generally found with this syndrome, a pressure of 14 cm CSF has been recorded in the literature with a documented CSF leak (Mokri et al. 1999), and one of us (CB) has documented a leak with an opening pressure of 18.6 cm CSF. Such estimations of lumbar CSF pressure open the equally vexed question of the best way to do a lumbar puncture. We find that a recumbent, relaxed patient who is flexed and comfortable, is a helpful baseline, but recognize this can sometimes be a challenge to achieve. Secondly, it remains unclear whether there needs to be a continuing leak of CSF or simply abnormal pressure regulation, because the syndrome may be present without any demonstrable leak. Possibly this is just a reflection of the imperfect sensitivity of the investigations available (i.e. false negatives).

**CLINICAL PICTURE**

The most common cause of the problem is dural puncture for diagnosis, spinal anaesthesia, intrathecal chemotherapy, myelography or, occasionally, inadvertently during epidural anaesthesia. The reported frequency of post-dural puncture headache varies from less than 1% to more than 50%, depending on the type of patients studied, associated procedures such as the introduction of anaesthetic or radio-opaque dye into the CSF, the definition of the headache, and the method of follow-up (Sand 1989; Kuntz et al. 1992; Peterman 1996). The headache usually develops within 48 h of dural puncture, making it straightforward to diagnose, and tends to settle rapidly with bed rest.

In the more chronic situation, the patients typically present with a history of headache coming on from one day to the next, i.e. within 24 h or just a few days, but by the time they are seen they may well have forgotten these details of the onset. The pain is generally not present on waking, worsens during the day, and is relieved by lying down, usually within minutes. It takes only minutes to an hour for the pain to return when the patient is again upright.

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With increasing time from the index event, or indeed with long histories after spontaneous onset, the link between posture and the headache may weaken. Therefore, it is very important to try and take patients back to the initial period and tease out the history at that point. This may not be possible if they cannot remember the exact details, but any mention of new onset, i.e. onset of headache over 24–72 h, or hint of variability with posture, needs persistent clinical enquiry. Patients may volunteer, or a history may be obtained stating that soft drinks containing caffeine provide temporary respite (see below).

**INVESTIGATIONS**

In a patient presenting with typical symptoms after a lumbar puncture, investigations are generally unnecessary. Otherwise, the investigation of choice is MRI with gadolinium (Fig. 1), which usually shows a striking pattern of diffuse pachymeningeal enhancement (Mokri et al. 1997). However, leaks have been documented without such enhancement (Mokri 1999), and this may occur in as many as 10% of cases (Mokri, pers. comm.), a figure in line with our own experience. The finding of diffuse meningeal enhancement is so typical that, in the presence of an appropriate clinical picture, we move directly to treatment. Of course, meningeal enhancement...
This may demonstrate both the leak itself as well as early emptying of tracer into the bladder, which is good evidence of a leak. However, the procedure is invasive, as it requires the injection of $^{111}$In-DPTA into the CSF space via a lumbar puncture. Alternatively, a CT myelogram or spinal T2-weighted MR scan may sometimes identify a CSF leak.

**MANAGEMENT**

Treatment is bed rest in the first instance. We have seen false positive transient improvement in persistent low CSF volume headache with chiropractic manipulations, and other similar therapies, where the treatment requires the patient to lie down for a prolonged period. There is some evidence from a systematic review of three small, randomised, placebo-controlled trials to support the use of methylxanthines for post-dural puncture headache (Sudlow & Warlow 2002a; Camann et al. 1990; Schwalbe et al. 1991; Sechzer & Abel 1978). Overall, there was a relative reduction of over 50% in severe post-dural puncture headache during follow-up (Fig. 2).
In our own experience, we have found that intravenous caffeine is often very effective. The ECG should be checked for any arrhythmia prior to administration. Our practice is to give an infusion, after obtaining a typical clinical history and MRI findings, and repeat this in 4 weeks if there is no response.

However, this result is difficult to interpret, because the method of randomization and treatment allocation was not stated in any of the publications, the intervention varied between trials, follow-up was short (2–24 h only), and the number of outcome events was small. These trials did not find any excess risk of tachycardia, flushing, gastric upset, jitteriness or other adverse effects among patients receiving methylxanthines (Sudlow & Warlow 2002a). However, insomnia was significantly more common among patients treated with caffeine than among those receiving placebo in a randomised controlled trial of caffeine for the prophylaxis of post-dural puncture headache after myelography (Strelec et al. 1994).

In our own experience, we have found that intravenous caffeine (500 mg in 500 mL saline administered over 2 h) is often very effective. The ECG should be checked for any arrhythmia prior to administration. Our practice is to give an infusion, after obtaining a typical clinical history and MRI findings, and repeat this in 4 weeks if there is no response.

REFRACTORY POST-DURAL HEADACHE

There remains a small group of patients who have the typical history as outlined above, in whom the headache is persistent,
but a leak is not identified, so that a targeted blood patch cannot be performed. A blind blood patch can be attempted but may fail. Such patients may have had sustained CSF leaks that have resolved, leaving altered CSF dynamics, with perhaps a lowered pressure setting in the choroid plexus, and sensitization of meningeal afferents. Such cases are therapeutically very challenging, and our approach is to treat the headache as if it were, in the broadest sense, a post-traumatic headache.

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REFERENCES