

In the ME ICC 2011 criteria, headaches are not broken into strict subtypes (like a neurology textbook classification). Instead, they are included under neurological impairments, where the emphasis is on change from baseline:

“Headaches often of a new type, pattern, or severity.”

That said, in clinical descriptions of ICC-defined ME patients, the headaches most commonly reported tend to fall into a few recognizable patterns:

\*Migraine-like headaches

Often severe, throbbing, and may come with nausea, light/sound sensitivity, or visual disturbance.

\*Tension-type / pressure headaches

A constant “band-like” tightness or pressure sensation, often worsened by cognitive or physical exertion.

\*Exertional or post-exertional headaches

Triggered or significantly worsened after physical or mental activity, often linked with PEM (post-exertional malaise).

\*Cervicogenic-like headaches (reported in some patients)

Pain starting in the neck or base of skull and radiating upward, sometimes worsened by posture or muscle strain.

So, under ICC 2011, the key point isn't the exact headache label - it's that headaches are part of the neurological symptom cluster and are typically new, altered, or more severe than before illness onset, especially in the context of PEM and sensory sensitivity.

Headache management in people who meet ME ICC 2011 is generally symptom-based and conservative, because headaches are usually part of a broader neurological + energy metabolism dysfunction pattern (often tied to PEM) rather than a standalone headache disorder.

Here's a clear, practical overview:

1. Pacing (core intervention in ME)

This is often the most important factor.

\*Avoiding overexertion (physical, cognitive, sensory)

\*Preventing post-exertional malaise (PEM) is key, because PEM commonly triggers or worsens headaches

\*Structured rest periods before and after activity

## 2. Sensory and cognitive load reduction

Headaches in ME are often aggravated by stimulation:

\*Low light / sunglasses indoors if needed

\*Reducing screen brightness and screen time

\*Quiet environments or noise reduction (earplugs/noise-cancelling headphones)

\*Limiting multitasking or prolonged concentration

## 3. Sleep support

Because non-restorative sleep is common:

\*Regular sleep-wake routine (as tolerated)

\*Reducing stimulants (e.g., caffeine late in day)

\*Managing night-time sensory disturbance

## 4. Hydration and basic physiological support

Some patients find benefit from:

\*Adequate fluids

\*Electrolytes (especially if orthostatic intolerance is present)

\*Regular small meals to avoid energy dips

## 5. Medication (symptom-targeted, cautious use). Depends on headache type and patient tolerance:

\*Simple analgesics (e.g., acetaminophen/paracetamol or NSAIDs) for episodic relief

\*Migraine-specific treatments (e.g., triptans) if migraine phenotype is present

\*Preventive medications may be considered in frequent/severe cases, but sensitivity and side effects are a concern in ME

## 6. Treating comorbid contributors

Headaches may be worsened by:

\*Orthostatic intolerance (POTS/dysautonomia) → fluid/salt strategies, compression garments, sometimes medications

\*Neck muscle strain / posture issues → gentle physiotherapy (carefully paced, not exertion-heavy)

\*Medication overuse headache if analgesics are used too frequently

7. Avoiding common pitfalls in ME

\*Aggressive exercise programs (can worsen PEM and headaches)

\*Overstimulating “rehabilitation” approaches

\*Ignoring PEM as the central driver of symptom flares

Key ICC 2011 framing

Headache management in ICC ME is essentially:

Reduce triggers → prevent PENE → support neurological load tolerance → treat symptoms cautiously

References

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<https://pdfs.semanticscholar.org/.../88d9cef78c373690d046...>

<https://headaches.org/resources/the-complete-headache-chart/>. The Complete Headache Chart

<https://www.advancedheadachecenter.com/common-types-of...> (Picture below comes from this site.)

<https://pmc.ncbi.nlm.nih.gov/articles/PMC7309998/>

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