Dynamic Chiropractic

The Headache Diagnosis and Management Series for the Chiropractor, Part II

The chiropractor sees two basic groups of headache sufferers: those that obtain lasting relief from chiropractic and those that do not. This series of articles is meant to focus on the latter group of patients with the goal of identifying which treatments will and will not work. The goal is to improve our effectiveness in the management of chronic headache sufferers.

The first matter at hand for the chiropractor when confronted with a chronic headache sufferer is to identify the type of headache.

We will focus on one common form of headache known as chronic daily headache (CDH). Later in the series, we will discuss several other forms of headache including cervicogenic headache.

About one-third of patients who seek treatment suffer from daily or near daily headache. To qualify for the diagnosis of CDH, a person must have headaches for more than 15 days per month or 180 days in a year. Approximately one-fifth of these sufferers experience daily headaches from the onset. The remaining four-fifths began with intermittent headaches that became CDHs.

CDH is divided into five subcategories:

- New persistent daily headache
- Chronic tension-type headache
- Transformed migraine
- Cervicogenic headache
- Post-head trauma (with or without migrainous features)

We will discuss each of these headaches later in the series. For now, let us look at the most interesting aspect of CDH. All five subcategories of CDH can be associated with analgesic overuse. This fact cannot be overstated and should not be overlooked as it is an integral part of headache management for the chronic sufferer. Failure to address this issue probably accounts for the greatest majority of treatment failures.

We have discussed this issue before (see "Don't Take Aspirin but Call Me in the Morning" in the October 6, 1997 issue). Headaches resultant from medication misuse have been variously referred to as analgesic rebound headache, analgesic headache and drug induced headache.

However, the preferred term is "rebound headache" which is used to characterize the headache-perpetuating tendency to resort to taking "immediate relief" medications (see Table I). Rebound headaches are not the same as recurring headaches.

Table I: Commonly Used Daily Symptomatic or Immediate Relief Medications Linked with

Analgesic Rebound Headache

- Butalbital/aspirin
- Acetaminophen
- Caffeine with or without codeine
- Natural or synthetic codeine-containing preparations
- Aspirin or acetaminophen with caffeine
- Ergotamine with or without phenobarbital
- Propoxyphene (Darvon-N, USP, Lilly)
- Acetaminophen
- Nasal decongestants and antihistamines
- Aspirin

Now, let's clear up any confusion between these two commonly used headache terms, namely, recurring and rebound.

Recurring headaches are those that recur with the same headache and are significantly relieved by an abortive agent. Recurrence of the headache should occur within the expected natural duration (e.g., the next migraine attack).

Rebound headache means that there is a perpetuation of head pain in the chronic headache sufferer caused by frequent and excessive use of immediate relief medication. This type of headache may be viewed as a self-sustaining, rhythmic "headache-medication cycle." These daily or near daily headaches are associated with an irresistible and predictable use of immediate relief medications as the primary means of relieving headache attacks.

The rebound headache patient sees significant improvement with mere discontinuation of the offending medication(s). Although it is beyond the scope of this article, there is ample data in the literature to support the existence of rebound headache.

What Are the Clinical Features of Analgesic Rebound Headache?

Fortunately, there are a number of clinical characteristics to assist in identifying rebound headache in our patients with chronic headaches.

1. The headaches are refractory, daily or near daily.
2. They occur in a patient who uses immediate relief medications frequently, often in excessive quantities.
3. The headache varies in its severity, type and location from time to time.
4. The headaches may be brought on by slight physical or intellectual effort.
5. The headaches are seen with complaints of nausea and other GI symptoms; restlessness;

anxiety; irritability; memory and concentration problems; and depression.

6. There is a drug-dependent rhythmicity of headaches with the headache emerging as the medication wears off. The patient may report a predictable early morning headache, particularly seen in patients who use large quantities of immediate relief medications.

7. Barbiturate-containing analgesics (e.g., Fiorinal, Esgic) suppress REM sleep. This is followed by REM rebound and results in awaking with severe headache.

8. The patient needs increasing doses of analgesics.

9. Withdrawal symptoms are observed when the patient abruptly stops taking the immediate relief medication(s).

10. There is a significant improvement of headache on discontinuing the offending medications.

Self-Test

1. Which of the following is/are presently acceptable explanations(s) for the production of headache?

1. Original sin.
2. The nitric oxide molecule.
3. Neural plasticity.
4. Frequent use of naprosyn.

Answer: Naprosyn is the only one of the four choices that is not considered to be a cause of headache.

Did you answer original sin? There are many interpretations for original sin as it relates to headache (e.g., innate weakness towards headache, guilt/stress), but this remains as an acceptable explanation for certain types of headache.

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