

Pediatric Headaches

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Although the pediatric chiropractic practice often is sought out for childhood conditions (e.g., otitis media, asthma, colic, enuresis, etc.), headaches are more common than most doctors realize. When a child has headaches, it is not uncommon for a parent to seek medical attention to rule out a brain tumor or other serious problems. Once the child has been examined and a serious disorder has been ruled out, the starts down the path of learning "to live with it." The parent or child may administer over-the-counter medication, or opt for medically managed pharmacology.

One Swedish study of 9,000 children discovered that over 70% have had headaches by the age of 15.¹ Smith reports from a 1988 survey the frequency of severe headaches in those under the age of 18 to be 25.³ per 1,000 population, 9.9 per 1,000 for children under the age of 10, and 45.8 per 1,000 for those from ages 10-17.²

An Australian study of 900 children ages 10 to 18 reported only 36.8% never experienced a headache.³ This study revealed that 33.7% of the youth experienced headaches every 2-3 weeks or once a month; 24.8% every few days or once a week; and 4.6% experienced a headache almost all the time. The girls were more likely to have headaches with a higher frequency (once a week).

Sillampaa and Anttila in 1996 reported the increasing prevalence of headache in seven-year-old schoolchildren.⁴ The study reported the occurrence of headaches during a six-month period increased from 45.4% in 1974 to 51.5% in 1992. Migraines increased during that time from 1.9% to 5.7%.⁴

Linnet et al. in a 1989 *JAMA* report revealed that 15% of females and 6.9% of males aged 18-23 had consulted a physician within the previous 12 months for headache.⁵

The International Headache Society has defined the headache in a classification table (see Table I). The migraine and tension type headache are more common; the cluster headache less common. Headache may be secondary to or a manifestation of another illness. Recent trauma or the suspicion of an underlying organic disorder requires further evaluation.

[Table I: International Headache Society -- Headache Classification. Silberstein SD. Differential diagnosis of headache. *Hospital Med* 1994;30(1):49-54, 59-60. In: Anrig C, Plaughter G (eds.) *Pediatric Chiropractic*. Baltimore, MD: Williams & Wilkins, 1998, p. 578. Reprinted with permission from the publisher.]

International Headache Society: Headache Classification

Migraine

1.1 *Migraine without aura*

1.2 *Migraine with aura*

1.3 *Ophthalmoplegic migraine*

1.4 Retinal migraine

1.5 Childhood periodic syndromes that may be precursors to or associated with migraines

1.6 Complications of migraine

1.7 Migrainous disorder not fulfilling the above criteria

Tension-type Headache

2.1 Episodic tension-type headache

2.2 Chronic tension-type headache

2.3 Headache of the tension type not fulfilling the above criteria

Cluster Headache and Chronic Paroxysmal Hemicrania

3.1 Cluster headache

3.2 Chronic paroxysmal hemicrania

3.3 Cluster headache-like disorder not fulfilling the above criteria

Miscellaneous Headaches Unassociated with Structural Lesion

Headache associated with head trauma

Headache associated with vascular disorders

Headache associated with a nonvascular intracranial disorder
Headache associated with substances or their withdrawal
Headache associated with noncephalic infection
Headache associated with a metabolic disorder
Headache or facial pain associated with a disorder of the cranium, head, eyes, ears, nose, sinuses, teeth, mouth or other facial or cranial structures
Headache: not classifiable

Management of headaches by spinal adjustments has been documented. In the *Journal of Chiropractic Pediatrics*, Anderson-Peacock describes five cases which responded well to chiropractic adjustments. Secondary problems (e.g., back and/or extremity pain, sinus and GI tract) were also mentioned as part of the patient's profile.⁶

Hewitt published a case study of a 13 year old with headache and neck pain.¹ After chiropractic evaluation and treatment, the patient had no headaches by the second week, and by the fourth week no reoccurrence of her symptoms. Lewit studied a group of 30 children with nonmigrainous headaches. He stated that 28 of the children had "excellent" results from manipulation. In another group of 27 children who suffered from migraine headaches, 24 had excellent results.⁷

At the 1994 National Conference on Chiropractic Pediatrics, Cochran presented a case of a 10-year-old male with a three-year history of migraine headaches.⁸ During the first month of chiropractic care, it was reported that he only had two prodromal episodes, but no full migraines.

The chiropractor should attempt to understand the nature of the headache with the consultation. Younger children can present as a more difficult case because doctors may not feel that their questions are unveiling the problem. First, do not ask the question as if you are speaking to an adult. Rather, pose the question, "Does your head ever hurt?" The doctor may even want to point to their head while the question is being asked. Attempt to pinpoint the location: "Where does it hurt?" "Does the headache feel like a little one, or a big one?" Determine if there is a pattern to the headaches (e.g., time, food trigger, etc.).

One excellent tool for understanding headaches is to keep a journal of occurrences. A morning

headache may be a result of a stomach sleeper placing their cervical spine in constant rotation. A weekend headache may be the result of sleeping in and delaying the routine of bowel or bladder elimination, and thus creating toxins in the system. A pre-lunch or after-school headache may be a sign of hypoglycemia. The use of backpacks may cause a repetitive stress syndrome in the cervical and upper thoracic spine. Also rule out vision problems and the possible need for glasses. The influence of food or chemical products in the diet of the child, such as Nutrasweet, sulfates and sulfites (in hot dogs and lunch meats), caffeine and chocolate may be potential triggers to a headache.

For young girls and teens, the onset of the menstrual cycle may be the start of a future of migraine headaches. Many chiropractors have had positive clinical results for this disorder with the specific analysis of the lumbar spine. Adjusting the vertebral subluxation in this region may eliminate or diminish the severity of the migraine.

In the treatment of the pediatric patient with headache, there is no one specific vertebral subluxation(s) site that one must expect to find as the cause of the disorder. The chiropractor should evaluate the entire spine for the vertebral subluxations(s). The purpose of a specific adjustment is to optimize function (e.g., neuropathophysiology and myopathology).

To increase a more positive clinical outcome, the chiropractor should follow two fundamental principles: be more specific in your spinal analysis and adjustment, and do not perform multiple adjustments during the visit (less is sometimes more).

Considering the staggering number of children who suffer from headaches, the chiropractor should contact the professional community and discuss chiropractic care as another option rather than the introduction of random chemicals for the child. Continue your efforts by educating the lay person to the benefits of chiropractic care in the elimination or diminishment of headache. If the general adult population is unaware of the great results chiropractic care can provide for headache, how many of these parents are leaving their children home not realizing a natural solution is in their grasp?

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AUGUST 1998

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