Dynamic Chiropractic

HEADACHES & MIGRAINES

Headache Pain: Treat or Refer?

TRIAGE AND TREATMENT CONSIDERATIONS FOR PATIENTS WITH HEADACHE AND FACIAL PAIN.

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Headache is a leading cause of disability worldwide and the ninth most common reason for a visit to the doctor in the U.S. However, headache (HA) is a symptom and before we can discuss treatment, we need to review the diagnostic categories of HA and identify patients needing immediate referral, as well as those who can stay for treatment.

Headache Categories

There are over 200 HA disorder classifications, divided into three categories: primary, secondary, and cranial and facial neuropathies. Primary HA is the second cause of disability worldwide (chronic LBP is #1) and is often treated by PCPs as opposed to specialists. Primary HA includes migraine with and w/o aura, tension type, cluster, and medication overuse headache (MOH).

Table 1 reviews the characteristics of primary HA with the exception of MOH, which will present as an exacerbation of the patient's current HA disorder. MOH may also present with withdrawal symptoms, and *it is best to co-manage MOH with the patient's medical specialist*.

TABLE 1

	Migraine	Tension Type	Cluster
Temporal Pattern	Recurrent attacks lasting a few hours to days	Recurrent attacks lasting a few hours to days	Frequent (several a day), short attacks (15 minutes to three hours)

Typical Characteristics	Often unilateral & pulsating	Generalized; may be unilateral or radiate to the neck	Strictly local; involving eye or temporal
Intensity	Moderate to severe	Mild to moderate	Extremely severe
Associated Symptoms	Nausea and/ or vomiting, photoand/ or phono- and/ or osmophobia	None typically; may have mild nausea, (not vomiting), photo and/or phonophobia	Strictly ipsilateral; autonomic features: red and/or watering eye, running or blocked nostril, ptosis
Reactive Behavior	Avoids physical activity, preference for dark and quiet	None	Marked agitation: cannot lie still during attacks

Migraine with aura only affects one third of migraineurs and even less experience aura symptoms with every HA attack. The aura generally precedes the HA (but may also accompany), involves visual symptoms >90 percent of the time and is usually a slowly enlarging scintillating scotoma (if asked, patients may draw a jagged crescent to represent the flickering). Also common is unilateral paraesthesiae and/or numbness of the hands, arms and/or face. *An aura that presents with vertigo, tinnitus, diplopia, ataxia, speech and/or language disturbances or motor disturbances needs specialist referral*.

Clinical Tip: A patient may have more than one HA disorder in their history and/or at the time of evaluation. Be sure to evaluate for each separately. For example, Tom Smith has a history of cluster HA and presents with a tight band around the head. Take the time to differentially diagnose a possible tension-type HA from a new-onset cluster HA.

Trigeminal neuralgia is a common cause of facial pain. It presents as short (up to two minutes), excruciating bouts of stabbing / electric shock-like pain in the trigeminal nerve distribution, mostly in the second and third branches. It often has a sudden onset and will be triggered by sensory stimuli such as touching, washing, applying makeup; or even talking, eating, chewing, drinking or smoking. Trigeminal neuralgia is twice as prevalent in women and is uncommon in children.

Clinical Tip: If you are the first provider to be seen for an apparent trigeminal neuralgia or cluster HA, immediate referral is required.

Secondary HA is related to an underlying pathology and often falls into the yellow- or red-flag category. Patients present with various additional symptoms including neurological, cognitive, gait and constitutional findings such as speech disturbances, ataxia, fever, weight loss or stiff neck. Table 2 highlights common reasons for immediate referral.

TABLE 2

Reasons for Referral
• Diagnostic uncertainty
• Progressive worsening of symptoms
• HA with motor weakness or CNS symptoms
• New HA that is severe or different
• First-time cluster HA or trigeminal neuralgia

- HA worsens with activity
- Concerns for secondary HA
- HA with stiff neck, fever, personality change

Clinical Tip: A recurring HA with strenuous activity needs referral, as does a new- or recent-onset HA that is of a different character than previously experienced.

Cervicogenic HA is a secondary HA that is worsened by neck movement, sustained awkward head position, or external pressure over the cervical or occipital regions. The cervical flexion rotation test is 100 percent sensitive and 94 percent specific to differentially diagnose cervicogenic HA from migraine; however, it only assesses motion at C1-2. This secondary HA we do treat and does not generally require referral.

Clinical Tip: The cervical flexion rotation test is performed with the patient supine and the cervical spine fully flexed passively. The patient's head is then passively maximally rotated right and left. If motion is significantly limited (normal is 44 degrees) and painful, cervicogenic HA is suspected.

Besides trigeminal neuralgia, facial pain can be related to temporomandibular joint disorder (TMD). These patients will have a history of bruxism, clenching, abnormal / painful jaw movements, and often present with myofascial trigger points. In the triage of facial pain, a TMD history is appropriate.

Multimodal Management

HA management involves a true multimodal approach. Postural correction and CMT to the areas of joint restriction within the entire spine, and TMJ with soft-tissue work for trigger points and myofascial concerns, are appropriate. Nutritionally, the gut-brain axis may be involved, as well as specific food or chemical sensitivities. Simply avoiding extreme changes in blood sugar and maintaining hydration levels are important; and the MIND Diet (a blend of the DASH and Mediterranean diets) has shown benefit in migraine management.

Clinical Tip: *Women migraineurs with aura should not be prescribed combined hormonal contraceptives (CHCs) containing estradiol.* Both are independent risk factors for stroke in young women. In addition, a change from migraine w/o aura to migraine w/aura after starting CHCs is a signal to stop immediately, while progestogen-only contraception is acceptable with any type or subtype of migraine. Hormone replacement therapy is not contraindicated in migraine with or w/o aura in postmenopausal women.

Primary HA, cervicogenic HA and TMD-related facial pain are all conditions that will respond favorably to the whole-body approach of chiropractic. But remember: first, you need to know if your patient should stay or if they need to go.

Resources

- Askarpour M. Associations between adherence to MIND diet and severity, duration and

frequency of migraine headaches among migraine patients. *BMC Research Notes*, 2020;13.
- Jahromi SR, et al. Association of diet and headache. *J Headache & Pain*, 2019;20:106.
- Rezaeian T. The impact of soft tissue techniques in the management of migraine headache: a randomized controlled trial. *J Chiro Med*, Dec 2019;18(4):243-252.
- Steiner TJ, et al. Aids to management of headache disorders in primary care. *J Headache & Pain*, 2019 May 21;20(1):57.
- Mieszko Wieckiewicz M, et al. Reported concepts for the treatment modalities and pain management of temporomandibular disorders. *J Headache & Pain;*2015;16:106.

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