OVERCOMING HEADACHES *and* MIGRAINES

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Chapter 1

What Kind of Headache Do I Have Anyway?

The study of the origin and life cycle of headaches has left scientists with more questions than answers. Even with the latest high-tech equipment, researchers still fall short in attempting to explain the start-to-finish process. Doctors still don't know exactly why headaches begin and what causes them to stop once they've begun.

The good news is, we don't need to know exactly how the brain processes your headache in order for you to find some relief. And let's think big, beyond finding relief—and more toward finding a lasting cure! In order for that to occur, what we really need to find out first is what *type* of headache you have. Then we can set off on the road that leads toward your own personal headache-treatment plan. The mission of this chapter is to give you enough information to be making your own headache diagnosis. Basic details of headache types will help lead you in one direction or another. Further into this book you will find detailed descriptions of each headache type and a plan of action that can be taken, both by you and by your health providers.

Becoming a "Headache Student"

Certainly not all headaches are the same, so it is vitally important that your headache condition be properly diagnosed. You need to do your part in becoming a student of your own headaches so you will be able either to diagnose yourself or aid your physician in reaching a correct diagnosis. *Accurate diagnosis is key!* For you to become a good

headache student, you must know *what* to be observing when it comes to your head pain.

By the way, I suggest you begin keeping a daily headache diary, like the one provided for you on pages 23–24. The good thing about keeping a headache diary is that you don't have to hide it from your siblings. Seriously, if you are like me, your memory of daily events fades with time. Reliable information gathering is very important, so it shouldn't be entrusted to memory alone.

Sensitive Structures

Though much remains unknown, there are some important things that *are* known about head pain. Interestingly enough, your brain itself is incapable of feeling pain (even though during some headaches you feel as though your brain itself is throbbing!). However, scientists have found there are many other structures within your head and neck that are pain-sensitive. These include certain arteries, veins, and nerves of your brain and neck; your brain's coverings (the meninges); the joints of your upper neck; your first cervical (neck) disc; the skin of your scalp; and the muscles of your head and neck. With all these different pain-sensitive structures, no wonder it's taking so long to figure this whole thing out! And for certain types of headaches, science points to the brain's own chemical reactions as the "match that lights the fire."

How often? The first item to observe and document is the *frequency* of your headaches. How often do they occur? How many do you get in an average month? Headaches that occur less than 1 time per month are considered to be *infrequent.* Between 1 and 15 episodes per month categorizes head pain as *frequent.* If you are experiencing more than 15 headaches per month (or constant headache), your condition is viewed as *chronic.*

When and how long? Along with frequency of headache, you want to note the time at which each of your headaches began and the length of time each one lasted (*duration*). This will give clues about which of the types of headache you may be suffering. (Believe it or not, some headaches characteristically begin in the middle of the night

or at the end of a workday.) Other headaches have characteristic durations. Documenting duration also shows your physician how much of your life is spent in pain and, therefore, how serious the situation actually is for you.

How intense? Next to note is the *intensity* of your pain. This is easily recorded by using a numerical pain scale of 1 to 10. Thus, "1" is when you just barely perceive a pain sensation, and "10" is an "emergency room" headache. Where does your headache rank on that scale? Document it in your headache diary. (Just to let you in on a secret, if you report to your doctor or therapist that your headache is a 15 on a scale of 1 to 10, they will immediately view you as a "symptom magnifier" and wonder if there is a psychological factor contributing to your headaches—even though you might just be trying to drive home the fact that your headaches are unbearable. So take my advice, stick to the scale.)

Where? *Location* of pain answers three main questions for your health practitioner:

1. Is the problem unilateral (one-sided) or bilateral (both sides of the head)?
2. What structures may be involved in the creation of the headache? (Different structures have the capability of *referring* pain—making pain travel—to different areas within the head and face.)
3. Is there an initiating area of pain which may be acting as a headache trigger (for example, the neck or jaw).

So keep track of where in your head or neck your pain begins and where it spreads to during the course of each headache.

Specific sensation? Another helpful item in diagnosing a headache is something that is referred to as the *quality* of pain. Specifically, does your headache feel like a tight band around your head? Is it a dull ache? A sharp, shooting pain? More of a throbbing sensation? Different types of headaches are associated with different pain qualities, as you will soon discover.

What else? *Other associated symptoms* present are also important for you to note. See if you recognize any of these:

- stiff or painful neck
- nausea
- vomiting
- visual disturbances (flashing, blinking lights, distorted images, and so on)
- sensitivity to bright lights
- sensitivity to loud noises
- sensitivity to certain strong odors
- nasal stuffiness
- runny nose
- eye tearing
- eyelid swelling
- numbness (loss of sensation)
- tingling (pins and needles)
- loss of part of your visual field
- face drooping
- fatigue, yawning, or both
- agitation

By taking care to pay attention to and document any of the above signs and symptoms related to your headaches, you will begin to unravel the mystery of which headache type you suffer from. The better you are at gathering the needed clues, the closer you will be to finding lasting help. The best aid you can bring to a professional who is helping you is your headache history. Come to your physician's or physical therapist's office armed with at least a month of legible, well-taken notes. Any health-care practitioner will be impressed by a "student" who obviously has done their headache homework.

Daily Headache Diary

Day of the month	**Intensity** (1-10)	**Duration** (min-hrs)	**Location** (specific)	**Quality** (ache, throb, squeeze, sharp)	**Associated symptoms** (see list below)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					

A. stiff or painful neck
B. nausea
C. vomiting
D. visual disturbances*
E. sensitivity to bright lights
F. sensitivity to loud noises
G. nasal stuffiness
H. runny nose
I. sensitivity to strong odors
J. tingling (pins and needles)
K. eye tearing
L. eyelid swelling
M. face drooping
N. numbness (loss of sensation)
O. fatigue, yawning
P. agitation
Q. loss of part of your visual field

* Visual disturbances include flashing, blinking lights, and distorted images.

Daily Headache Diary

Day of the month	**Intensity** (1-10)	**Duration** (min-hrs)	**Location** (specific)	**Quality** (ache, throb, squeeze, sharp)	**Associated symptoms** (see list below)
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					

A. stiff or painful neck
B. nausea
C. vomiting
D. visual disturbances*
E. sensitivity to bright lights
F. sensitivity to loud noises
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J. tingling (pins and needles)
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P. agitation
Q. loss of part of your visual field

* Visual disturbances include flashing, blinking lights, and distorted images.

Primary vs. Secondary Headaches

There are so many different types of headaches people experience: the one that comes along with your flu or sinus infection, the "I've had a stressful day" headache, the "sick" or migrainous headache, the "I just got hit in the head with a hard object" headache, the post–motor vehicle accident headache—and let's not forget the hangover headache. Clearly not all these headaches are from the same source. And likewise, they are not treated the same way. The International Headache Society (IHS) has done the tedious task of defining and categorizing these various headaches into manageable *groups* and *types* (see sidebar). This then aids health practitioners and you, the headache sufferer, enormously by pointing treatment in the right direction.

Headache Specialists

The International Headache Society (IHS) is a worldwide group of scientists and physicians who study and analyze available research in the field of headache. From their findings they have created a *headache classification system* (or groups of headache types) based upon the cause and characteristics (signs and symptoms) of each particular headache. Now, these classifications have changed somewhat over the years depending upon the present and agreed upon scientific knowledge at the time of their meetings. In 2004 the IHS updated and revised their list of headache classifications from their previous list, published in 1988. (Of note was the addition of the *cervicogenic headache,* which we will get to later in this chapter.)

The IHS has assigned all headache types, first of all, into one of two groups: *primary headache* or *secondary headache*. In *primary headache,* the headache *itself* is the problem. (No underlying problem exists.) Under the primary-headache banner are four types:

1. The most common is *tension-type headache* (TTH), which is thought to affect 90 percent of all headache sufferers.
2. The second most common is the *migraine headache* (MI).
3. The third is *cluster headache* (CL).
4. The fourth is simply called *other primary headaches.*

Of course each of these types have subtypes, and on and on. Believe me, there is enough classification and information to *give* you a headache! I will give you a brief, painless summary of these different headache types below and then in greater detail in chapters 3 and 8.

Unlike primary headache, *secondary headache* occurs in response to an underlying condition. As you will come to discover, I hold a special interest in the recently classified secondary headache, named *cervicogenic headache* (CH), a headache originating in the neck structures. It is my professional opinion—and that of many of my physical practitioner colleagues—that many of the patients who have been diagnosed with TTH (tension-type headache) actually have CH. For this reason, my intervention for both of these diagnoses is the same. (We'll discuss them together in chapters 3 through 7.)

Other underlying conditions also known to produce headaches are infections, hormone or blood-sugar levels, or emergency situations such as brain aneurysm. These are important enough to spend an entire chapter on, so in chapter 2 we'll discuss possible causes of non-neck-based secondary headaches and what should be done about each one. Also in that chapter, I will give you important information on what I call an "emergency room headache." If you think you might be having one of those, by all means skip ahead! (You can come back to this spot later.)

For now, let me acquaint you with the three main types of primary headache, as well as my featured secondary headache, the cervicogenic headache. Maybe you will begin to recognize yourself in one of the following personal accounts.

Tension-type Headache

> The day started like any other day, up at 6:30 A.M. to shower and get ready for work. I got the kids off for school and sat down to look over my Day-Timer. I already knew this day's schedule was going to be heavy. So I had to plan well to fit it all in. As I pulled out my chair, I noticed my son had left his lunch box on the floor in his hurry to run out the door. Well, add a stop to his school on the way into work. When I had an idea of what my day needed

to look like, I packed up my own lunch and headed out (with a stop to drop off the orphaned lunch box).

I arrived at work five minutes late and walked into the waiting room to see that both my 9:00 and 9:30 appointments had shown up at the same time. Juggling, I treated them both, and the day's busyness just escalated from there. One of my patients showed up doubled over in pain (and late—which meant I had more to do in less time). With each appointment I felt my shoulders and neck tensing up more and more. I was falling hopelessly behind that morning, and now some patients were giving me an attitude. Stacked on my desk was a large pile of patient charts and insurance paperwork that would have to wait until the end of my day. By the time I got to write my treatment notes, I could feel a low-level squeeze developing around the circumference of my head. Great, a headache was brewing!

I left work late (what a surprise) and headed directly to the supermarket. Could I shop and be home before my kids' bus arrived back? I raced through the aisles, quickly making my selections, stood in a long line to pay, loaded my groceries into the trunk, and slid into the driver's seat. Exhaling slowly, I noticed my shoulders were not lowering as I breathed out. I was stressed out. And wow, was my head hurting! It felt as if someone had it pressed in a vise.

—M.U.

In a tension-type headache, it was traditionally believed that *tension,* or increased muscle tone, in the head or neck was *the* cause. In fact, when originally classified, TTH was given the name "muscle tension headache," and then later "tension headache." As time went on, new studies failed to find a greater amount of tension in the muscles of the neck and head of a TTH sufferer than in those of their migraine-suffering counterparts. Still, without any other "cause" to point to, the IHS simply added a clarifying (or vague) word to the name: tension-*type* headache. (This was because patients were still reporting "tension" preceding their headache events.) Today the word *tension* has a broader definition. It includes both emotional tension—stress, anger,

anxiety—and physical tension—bad posture, faulty ergonomics, neck injury, hunger, and fatigue.

While scientific researchers still have yet to define the exact cause of TTH, enough evidence exists to suggest that some of the brain's chemical changes are similar to those noted in migraine sufferers. This points to a possible brain-based pain syndrome. Even so, it is commonly accepted that neck dysfunction, posture, and positioning can be major triggers for TTH. And by addressing these specific areas, TTH can be made a thing of the past.

Now let's look at the characteristics of TTH to see if they might describe your headache type. The following list describes the common signs and symptoms.

Characteristics of tension-type headache:

- bandlike, bilateral squeezing, pressing, or tightening around the head
- lasts from 30 minutes to 7 days
- mild to moderate intensity (1 to 6 on a "10" scale)
- preceded by tightness in the neck muscles
- neck, scalp, or jaw muscles, or a combination of them, are tender to the touch
- may be relieved by the use of over-the-counter medications
- usually not physically debilitating

Migraine Headache

Migraine headaches seem to have always been a part of my life. My earliest memory of getting an "I'd rather be dead" headache was when I was nine years old. Although I cannot recall the exact nature of my first headache (what it felt like, how it started, and so on), I've had hundreds of migraines over the years and can fill in the details now with certainty. As I went through adolescence, it appeared that my headaches were "cyclical" and related to my menstrual cycle. No one ever called them "migraines" back then (1970s), but in hindsight I am sure that is what they were.

I would get them sporadically throughout my late teens and into my twenties.

By the time I hit my late twenties, migraines were becoming a regular part of my life. Typically, they would start with a subtle tightness on one side of the back of my head. (It took me a while to recognize this symptom as the beginning.) From there, they would progress to a vise-grip, throbbing headache that seemed to pulse behind my eye. Because my migraine headaches had increased in frequency, my doctor gave me some medication (Fioricet) to have on hand. When a migraine would strike, I would take my medication, get an ice pack to put over my eyes, and try to sleep. Most times this did the trick.

However, there have been multiple occasions over the years where the headaches did not respond to medication and I would get to the point of throwing up. Once this happened, it became a very difficult cycle to break. The more I threw up, the worse my headache would become; the worse my headache became, the more I threw up. I was miserable! When I couldn't get out of this cycle, my husband would eventually take me to the emergency room.

I wasn't looking for a diagnosis. I was there for one reason only… for the drugs—anything to stop the pain and nausea! The physicians in the emergency room always gave me a "cocktail" of an anti-nausea drug and a painkiller of some kind (usually Demerol). This usually allowed my body to relax enough (yes, I slept!) for the cycle to be broken. But even though the headache and nausea would stop, the entire episode really took a toll on my body, and it literally took a couple of days to feel like myself again.

—F.M.

People diagnosed with migraine headaches make up a much smaller percentage of the overall headache population than do those with TTH. Even so, there are approximately 33 million Americans who endure them. Migraines are an entirely different animal from TTH. Those who suffer with them even have a chic French name: *migraineurs* (pronounced "mee-gren-ERS").

In 1993 the world of suffering changed significantly for migraineurs. That was the birthday year of the first effective abortive medication available for the treatment of acute migraine. (*Abortive* means "tending to cut short.") Its name? Imitrex. This was a truly exciting day for migraineurs as well as for their doctors—who up to that point had been struggling to help their patients. Finally, some relief!

Another area of excitement in the treatment of migraines is not so new to me or to my fellow manual therapy practitioners. But many migraine-treating neurologists are just starting to discover the effectiveness of manual physical therapy treatment of the upper neck. I have long been amazed at the clinical success I've had when treating migraine patients who have upper-neck problems. For many migraineurs, these problems act as a noxious stimulator for their headaches. Once the issues are corrected, the neck no longer "strikes the match" to ignite their migraines. All this without medication! As you can tell, I'm excited—it may be *you* who can be helped by this intervention. (Look for more information on treatment of upper-neck dysfunction in chapters 4 through 7.)

Migraines are very complicated and diverse. Though they are associated with four distinct, progressive phases from start to finish—phases that are well defined and documented—only 20 percent of migraineurs actually experience all four stages. Below you will find a basic description of what a migraine episode *might* look like (with much more information in chapters 8 through 11). Remember, since you are attempting to determine a *probable* diagnosis for yourself here, see if these headache characteristics describe your own *in general.*

Characteristics of migraine headache:

1. Prodrome
   - sensitivity to light, sounds, or smell
   - stiff neck
   - fatigue
   - anxiousness
   - food cravings

- occurs hours to one full day before aura/headache phases

2. Aura (present in only 20 percent of cases)
   - visual disturbances
   - light and noise sensitivity
   - nausea, vomiting, or both
   - lasts less than 60 minutes

3. Headache
   - moderate to severe intensity (5 to 10 on a "10" scale)
   - unilateral (one side of the head)
   - pulsing quality
   - pain increases with activity
   - lasts for between 4 to 72 hours (that's three days)

4. Postdrome
   - fatigue, listlessness, no "get up and go"
   - euphoria (It's over, thank God!)

Cluster Headache

I left the job early that day. All I know is, I was feeling "off." I didn't want to fall from the roof of the house I was working on that day. I figured the heat had gotten to me or something. When I got home I went straight to the fridge to get something cold to drink. Then it hit me. A pain in my right eye so sharp I couldn't stay still! I began pacing from one end of the kitchen to the other with my hand over my eye. I was shaking and sweating…and *hurting!*

My wife walked in with groceries in her arms, took one look at me, and dropped her bags on the table. "Honey, what happened to your eye? It's swollen—you look like you were in a fight!" I could barely talk, the pain was so bad. "Just take me to the hospital," I said. During the drive there I wanted to climb out the window. I just shook my legs and kept my head bent forward. I'm ashamed to say that the thought crossed my mind, *Maybe if I jump out of the car, someone will run over me and end this pain!*

> At the emergency room I was evaluated and had numerous tests performed, all of which came back negative. Meanwhile my headache was gone. (It left after about an hour.) The emergency room doctor asked if I had a history of alcohol abuse. I told him that I did, but had been "dry" for over eight years. The doctor believed I was having my first attack of a cluster headache. She said these headaches typically affect men, and often those with drinking problems. I didn't like the name of my diagnosis, 'cause "cluster" meant "a bunch." I was referred to a neurologist for follow-up. Before I got to see him, I had three more attacks. I call them attacks because these ain't no common headaches!
>
> The next two weeks were terrible. I had more of the same headaches, and then one day, as abruptly as they began, they stopped. Now I live in fear for the day they return.
>
> —T.S.

Often, with the first occurrence of a cluster-type headache, as with T.S. above, the victim will run (or be driven) to the emergency room. When I was in physical therapy school, I remember these headaches being called "suicide headaches"—they are so excruciating that people have been known to try to take their own lives just to end the misery.

Cluster headaches are so named because they occur in "clusters." A single headache will last only a brief period of time, but it will then recur multiple times in one day or multiple days in a row. This pattern goes on for months at a time and then stops for up to two years… before sometimes beginning all over again. Though cluster headaches will be addressed in greater detail in chapters 8 through 11, in terms of self-diagnosing, you should be able to either rule in or rule out this monster headache after reading through the descriptive list below.

Characteristics of cluster headache:

- severe intensity (10 on a "10" scale)
- unilateral (one-sided), temple or eye area
- sharp stabbing or burning pain

- eye tearing (same side as pain)
- nose congestion or running (same side as pain)
- eyelid swelling or drooping
- anxious pacing during attack
- from 15 to 90 minutes in duration per headache episode

Cervicogenic Headache

> The right side of my neck has always given me problems. For as long as I can remember it has been my "weak link." Lately my neck has been sore more often than not. I find myself constantly rubbing it. One day as I was walking on the treadmill, my right shoulder muscles went into spasm. From there the pain moved up into my neck, and I knew it was time to end my workout. By that evening, I had a sharp pain on the right side of my head and another pain between my right ear and my jaw. The next morning, the head pain was still there. My eyelids felt heavy, and by mid-afternoon the right side of my head felt like it had been hit by a brick! Don't you know, that headache lasted for nearly a week. I went to my physical therapist after that episode. I figured my neck must be getting worse.
>
> —L.M.

As of 2004, the cervicogenic headache classification is new to the International Headache Society's list (see sidebar on page 25). And boy, am I thrilled! From my treating experience, I've known that this has been a source of headache since I first began patient care in 1989. What *cervicogenic* means will give you important insight into where this type of headache originates. *Cervico* describes the cervical portion of the spine or neck area in the body (not the cervix of a woman's anatomy). The suffix *genic* comes from the word *genesis,* which means "the beginning." So if you put it all together, *cervicogenic* means, "a headache that has its origin in the structures of the neck." Most of the time, I will simply refer to it as a *neck headache.* (Simple enough for me…and easier to type!)

Characteristics of neck (cervicogenic) headache:

- one-sided (occasionally both sides)
- mild to severe intensity (1 to 10 on "10" scale)
- tender points in the neck muscles and over the upper neck joints
- can be preceded by trauma to the head or neck
- location: forehead, temples, eye area (can include base of skull/back of head)
- can be disabling, depending on severity

I hope that by now you may have been able to place your headaches into one of the four categories above. I say "your headaches" and not "yourself" because I don't believe your headaches should define you. They are something you *suffer with,* they are not *you.* Don't give your headaches any more credit than they deserve!

Some of you may now feel quite certain of which type of headache you have. But others of you may be unsure, even hopelessly confused. No need to be concerned. We've just begun. Several of the upcoming chapters are dedicated to fine-tuning your headache diagnosis. Once your headache type is determined, this book will offer you self-help, hope, and direction toward the management and cure of your headaches.