HEADACHE PAIN

***H**eadache (cephalgia)* is a diffuse pain that may occur in various parts of the head and is not generally confined to the distribution of any given peripheral nerve. *Headaches* vary between patients relative to precise location, time of occurrence, duration, frequency, and accompanying symptoms.

Malaise, disorientation, photophobia, irritability, sleeplessness, fever, nausea, vomiting, nervousness or vertigo may accompany *headache pain*. Some patients may additionally have pain in other areas of the body that they commonly associate with the *headache pain*, such as shoulder pain, stomach cramps, back pain, or neck pain.

Headache without fever may be an accompanying symptom of central nervous system tumors and abscesses, middle ear disease, sinusitis, the late stage of syphilis, cysts, simple or malignant encephalitis, multiple sclerosis, cephalic thrombosis, embolism, aneurysm, arteriosclerosis, mastoiditis, osteoarthritis, *shingles*, spondylitis, iritis, glaucoma, uremia, gout, diabetes, high blood pressure, low blood pressure, hypoglycemia ("hunger headaches"), motion sickness, sunstroke, allergies, and episodic malaria.

Headache with fever may accompany kidney disease, cephalic or meningeal disease, influenza, measles, gastroenteritis, typhoid fever, paratyphoid fever, various tropical illnesses, and the common cold.

Treatment

The most important step in the treatment of the *headache pain syndrome* is the evaluation. The *headache* can have so many causes that produce similar symptomology that without careful assessment, it can very easily be presumed to have a cause or causes that may not, in truth, be responsible. Special attention should be paid to the evidence supplied by trigger point surveys regarding the roles that cervical, shoulder or jaw muscles may play in the production of the *headache syndrome*.

The most common mistake is to assume that the first physical dysfunction discovered is the only cause. It is true that a *headache* will most commonly have a single source, but a considerable number of headache cases have multiple causes. For example, a patient may have a migraine (vascular) headache and a tension or referred pain *headache* from trigger point formations at the same time, with one syndrome (or set of symptoms) overlapping the other. Typically, these patients will not respond well to vasoconstrictor medication because the vasoconstrictor medication has little or no effect on a trigger point formation or the perception of its referred pain. In such cases, both sources of the *headache* must be treated if the patient is to be entirely relieved of pain.

Obviously, once the treatable causes of the headache have been established, each treatable cause should be treated appropriately.

Trigger Points

The following trigger point formations may, singly or in combination, refer pain into the area of the head: Masseter (deep), Masseter (superficial B), Temporalis (anterior), Temporalis (middle A), Temporalis (middle B), Temporalis (posterior supra auricular), Medial pterygoid, Lateral pterygoid, Posterior digastric, Frontalis, Suboccipital neck extensors, Occipitalis, Semispinalis capitis, Semispinalis cervicis, Upper trapezius [A], Posterior cervical group, Splenius capitis [A], Sternocleidomastoideus (superficial fibers), Sternocleidomastoideus (deep fibers), Orbicularis oculi (orbital), Zygomaticus (major), and Splenius capitis [B].