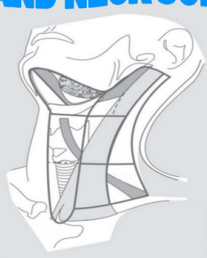
HEADACHES AND FACIAL PAIN

NAT'S NOTES IN OTOLARYNGOLOGY HEAD AND NECK SURGERY



Episodes 15.1 - 15.2

- Although 40% of population experience headaches (H/A), most are benign pathologies

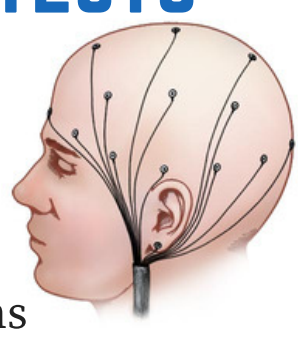
PHYSICAL EXAM

- Complete H&N exam
- Cranial nerves
- Palpate TMJ / muscles of mastication

HISTORY

- First occurrence? Timing?
- Quality of pain?
- Treatments tried?
- Associated symptoms? eg. aura, lacrimation
- Precipitating factors?

DIAGNOSTIC TESTS



- EEG
- CT and/or MRI
- EMG
- TMJ radiography
- Cervical spine films
- Psychometric testing

TENSION TYPE HEADACHE

- Most common type. Bilateral, non-throbbing, temporal / frontal radiating to occiput. Episodic v. chronic (>15d/month)
- Tx: stress management, posture correction, NSAIDs / ASA to abort. Antidepressants, muscle relaxants to prevent

MIGRAINES

- Inflammation of cranial vessels. Identified triggers: stress, menses, infection, trauma, wine
- Without aura: lasts 2-72hrs, unilateral, pulsating, moderate to severe pain aggravated with exertion WITH one of the following: nausea, vomiting, photophobia, sonophobia
- With aura: same diagnostic criteria (above) with transient symptoms of neurologic dysfunction - often visual
- Tx: serotonergic agonists ('triptans'), NSAIDs, lidocaine
- Consider prophylactic antidepressants (TCAs), B-blockers, calcium channel blockers or anticonvulsants (topiramate)

SHORT DURATION HEADACHES

- Cluster young males. Nocturnal onset, clusters of 15-180mins. Autonomic hyperactivity (ptosis, miosis, conjunctival injection). Tx with serotonergic agonist, high flow O2, intranasal lidocaine, high dose steroid taper
- Trigeminal neuralgia females > males. Stabbing pain in V2/V3 distribution. Tx with carbamazapine, gabapentin
- Idiopathic stabbing <1 sec migratory pain. Tx with NSAIDs

EMERGENT HEADACHES

!! Subdural hematoma, subarrachnoid hemorrhage, temporal arteritis, HTN crisis, post-traumatic, CNS infection