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J Eric Piña-Garza - pdf download free book


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CHAPTER 3

HEADACHE

APPROACH TO HEADACHE

Headache is one of the most common neurological symptoms and the source of frequent referrals to neurology. Proper diagnosis and management of headache has a positive impact on the lives of many children and their parents, and may significantly reduce the direct and indirect cost associated with this symptom. The World Health Organization ranks migraines as one of the top 20 disabilities in the world. Magnetic resonance imaging (MRI) and computed tomography (CT) scan are not always necessary or justified, and exposing the patient to radiation or anesthesia when not needed is not a good practice. A thorough history and neurological examination across the child better than imaging studies in most cases. Migraine is the most common headache diagnosis in children. Some of these children develop more frequent and less disabling headaches due to additional contributing factors (analgesics, caffeine, stress, depression, etc.). The prevalence of migraines increases from 1% in children age 3 to 7 years to 4-11% in children age 7 to 11 years and 8-23 % in adolescents. The mean age of onset for boys is 7 years and for girls 11 years (Lewis et al, 2004). Children with migraine average twice as many days lost from school as those without migraine.

Sources of Pain

Box 3-1 summarizes pain-sensitive structures of the head and neck. The main pain-sensitive structures inside the skull are blood vessels. Mechanisms that stimulate pain from blood vessels are vasodilatation, inflammation, and traction-displacement. Increased intracranial pressure causes pain mainly by the traction and displacement of intracranial arteries (see Chapter 4). The brain parenchyma, its ependymal lining, and the meninges, other than the basal dura, are insensitive to pain.

Pain transmission from supratentorial intracranial vessels is by the trigeminal nerve, whereas pain transmission from infratentorial vessels is by the first three cervical nerves. The ophthalmic division of the trigeminal nerve innervates the arteries in the superficial portion of the dura and refers pain to the eye and forehead. The second and third divisions of the trigeminal nerve innervate the middle meningeal artery and refer pain to the temple. All three divisions of the trigeminal nerve innervate the cerebral arteries and refer pain to the eye, forehead, and temple. In contrast, referred pain from all structures in the posterior fossa is to the occiput and neck.

Several extracranial structures are pain sensitive. Major scalp arteries are present around the eye, forehead, and temple and produce pain when dilated or stretched. Cranial bones are insensitive, but periosteum, especially in the sinuses and near the teeth, is painful when inflamed. The inflamed periosteum is usually tender to palpation or other forms of physical stimulation. Muscles attached to the skull such as the neck extensors, the masseter muscles, the temporalis, and the frontalis are a possible source of pain. Understanding of the mechanism of muscle pain is incomplete, but probably involves prolonged contraction (literally spasm). The extraocular muscles are a source of muscle contraction pain in patients with heterophoria. When an imbalance exists, especially in convergence, long periods of close work cause difficulty in maintaining conjugate gaze and pain localizes to the orbit and forehead. Decreased visual acuity causes blurred vision, not headaches. Impaired vision is a common delay in the diagnosis and management of migraines.

Pain from the cervical roots and cranial nerves is generally due to mechanical traction from injury or malformation. Pain follows this nerve distribution: the neck and back of the head up to

BOX 3-1 Sources of Headache Pain

INTRACRANIAL
- Cerebral and dural arteries
- Dura mater at base of brain
- Large veins and venous sinuses

EXTRACRANIAL
- Cervical roots
- Cranial nerves
- Extracranial arteries
- Muscles attached to skull
- Periosteum/sinuses

76

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