

Case Studies for the Treatment of Cervicogenic or Vertebrogenic Headaches

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Headaches that rapidly resolve following chiropractic treatment should empirically be classified as vertebrogenic or cervicogenic. One would think that headaches originating from the cervical spine would all be termed a “cervicogenic headache” however, cervicogenic headaches have criteria that limits its use for diagnosis. (This criteria really should be changed to reflect current scientific understanding and variability of the cervicogenic category). The classic definition of cervicogenic headache was originally proposed by Sjaastad in 1983. It has 3 criteria (1) unilateral headache triggered by head/neck movements or posture; (2) unilateral headache triggered by pressure on the neck; (3) unilateral headache spreading to the neck and the homolateral shoulder/arm. This classification of headache is still not accepted by The International Headache Society (IHC). Rather than recognizing this obvious form of headache, the IHC labels these headaches as a subset etiology of the tension-type headache or a variant of chronic daily headaches (CDH). The post traumatic patient may be diagnosed with new daily persistent headache (NDPH) a recent classification for headaches having multiple etiologies such as headache from post-concussion, subarachnoid hemorrhage, recent infection or other relatively rare disorders. The cervicogenic headache is one of the few types of headache where the source of pain originating from the reflexive pain generators in the spine can clearly and convincingly be identified based on segmental localization. Although the provocative cause of many headaches may be evident such as lumbar puncture headache, meningitis headache, toxic triggers or post concussion headache, the mechanism of pain production in most headaches is still incompletely understood or completely unknown. An alternative name for headaches originating from the spine is “vertebrogenic headache”. This term was proposed by Howard Vernon, D.C. a researcher and professor from Canadian Memorial Chiropractic College to avoid the limitation created by the overly narrow definition created by Sjaastad for cervicogenic headache.

Case study 1

Post traumatic 33 year old male patient with intensifying HA and nausea, disc herniations present at C3-4, C6-7 and T1-2. Normal brain MRI. Increased HA on cervical flexion. HA behind eyes, base of skull and vertex. Unrelenting HA for 3 months since MVA, unresponsive to Vicoden or Lortab. Multiple physicians consulted before referral to my office. Confirmation of spinal generators using manual axial traction applied to C6-7 on the left. Simultaneous axial decompression of C3-4 and suboccipital C1 level. HA reduction for 20-30 seconds with this maneuver. Treatment: Class IV K- laser to capsular region and intrinsic trigger points in the cervical spine. Results: Near complete resolution on first visit.

Case study 2

Post traumatic 57 year old female patient with significant cervical DJD and multiple broad based HNPs. HA for 6 months duration since MVA, patient was taking aspirin or Tylenol on a daily basis. A mild C7 radiculopathy was also present with variable intensity reported between visits. Her HA was the primary complaint. She had regular chiropractic care for 6 months without any reduction in HA intensity. Class IV K-laser was used in the suboccipital and posterior cervical intrinsic musculature as well as scapular elevator musculature. There was no change in the patient's symptoms following the first two treatments. Following the third laser treatment the patient had complete resolution of HA symptoms. On a follow-up visit five months later, there were no episodes of HA reported.
