

# Pediatric Headaches: Tension Headache

## Introduction:

Jamison was only four when she began a three-year battle with headaches. Her headaches affected her ability to sleep, eat, focus, participate in sports, interact socially and enjoy life. Her mother, Ruth, a physical therapist, was terrified. “It was awful. I see children every day who are suffering from brain tumors, head trauma, and other serious pathologies of the head. What if my child had something like that? It is hard for a mom not to worry. She was in so much pain. I was really scared.”

For several years her quest for answers was futile. She consulted Jamison’s doctor, a neurologist, and a pain specialist. Jamison was subjected to blood tests, brain scans, sinus imaging, and nearly every test imaginable. Most of the doctors prescribed pill after pill hoping one would work. “The buck was always being passed. I had a fist-full of prescriptions: allergy pills, sedatives, anti-seizure medications, opioids, anxiety medications, you name it... Everyone kept giving me Band-Aid solutions without determining the cause. As a mother, I was not excited about the prospects of a sedated headache free child or a child that would always be in pain.”

As children grow from preschool age to school age, there is a marked increase in the number of headaches experienced. In 1974, the prevalence of pediatric headaches among 7-year-olds was only 14%. By 1992, this number had increased to an alarming rate of 50%. This is especially worrisome when we consider that the pediatric headache is the earliest sign of a life-long predisposition for headaches. (H)

Doctors empathetically care for patients and want the best for them, yet pediatric headaches are very difficult to diagnose and treat. For both the doctor and the parents, the desire is to reduce the pain and suffering of the child with treatment which does not impair the child. This is double jeopardy for a loving parent.

The most common misconception is that a severe headache must be a migraine. This leads to the thinking that the only tools available to treat severe headaches are migraine medications which may have multiple adverse side effects, including the possibility of impaired processing and communication. Analyzing the gamut from medical school to neurology residencies and courses taught through the American Headache Society, the primary focus is the migraine headache and its treatment. When diagnostic tests and drugs fail to reduce the headache pain and/or the headaches become a chronic daily intrusion, parents have nowhere to turn, nowhere to go for help, and no answers. The only thing that is worse than chronic pain is no hope of relief. Fortunately for Ruth, a moment of prayer led her to seek out a long shot – her family dentist. She had little hope of an answer from a dentist about headaches. “He indicated that he could not treat the problem, but he knew of a specialist that treats tension headaches in children. What was even more exciting was that the treatment does not involve the long term use of drugs. He referred Jamison to Raleigh Facial Pain Services” (RFPS). Within three weeks of her initial exam, Jamison’s headaches were almost a thing of past. Within 2 months of active care, she was pain free. As an added bonus, she did not have to depend on mind altering drugs for the rest of her life. There is no better gift to give a parent or a child than a way to remove the child’s pain which, at one time, had appeared hopeless.

## Diagnostic Problems:

The scant literature available was written from a “migraine perspective” giving very little insight into the reality of tension headaches. Research laws are quite restrictive making it difficult to conduct adequate research to properly evaluate diagnostic and treatment modalities.

Typically, pathologies that have a simple basis for pain are more easily investigated and treated, but the pediatric headache is a multi-

faceted type of headache. The multifaceted nature of the pediatric headache contributes to the complexity of the diagnosis issue. Most experiments, by design, look at only one variable, rendering the studies to date uninformative as to the cause of the pediatric headache. When the multifaceted nature of pediatric headaches was discovered, it made sense why doctors were so frustrated with the lack of help from the sciences. Once science provides diagnosticians with additional tools, knowledge, and facts we are practicing an art that cannot be placed into the ordinary “fix it” box. Research is forthcoming, but it is slow.

Because of this relatively poor scientific research, there is difficulty in accurate diagnosis of headaches that have overlapping symptoms. For instance, the IHS Criteria List used in migraine diagnosis includes many of the symptoms also associated with tension headache. There are many migraine variants in addition to the “common” and “classic” migraines. A child could have severe tension headaches and moderate migraines, rendering the current standard diagnostic criteria invalid. There is one headache variant that can only be diagnosed by its reaction to a specific medication.

As you know, it can be quite difficult for a child to describe the pain they feel. It also takes a lot of effort to communicate on a child’s level. (MM) Most children do not have enough experience to be able to adequately convey the symptoms they are experiencing. Even adults have difficulty describing feelings and symptoms of pain. Language and cultural barriers also impair communication of symptoms.

Bruxism has long been associated with pediatric headaches. (L) Unfortunately, nearly 90% of the population are unaware of this bad habit. The nocturnal biting force is at least 6 times greater than during the day. (N) Grinding is easier for the parent to perceive because of its audible nature.

Parents with a child experiencing severely painful, undiagnosed headaches tend to create a fear of cancer. It is easy to understand this type of parental fear. They may even become frustrated with the doctor because there may have been 3 or more drug failures and no answers. Certainly an

MRI Brain is on the horizon, if not already done by this point in time. The undiagnosed headache sets the stage for this unfounded fear, unnecessary tests for the child, and creates possible waste of medical dollars. However, with a few weeks of conservative therapy for tension headache, the fear is removed, because the pain is alleviated.

### **Types of Headaches:**

The vast majority of headaches are tension headaches. According to currently available literature nearly 50% of pediatric headaches are tension headaches. (II) A few children suffer from migraines. Since pediatric studies are somewhat limited, most professionals rely on adult statistics when discussing the pediatric population due to the similarity of percentages.

In adults:

- 48% of females—tension headache (I)
- 38% of males—tension headache (I)
- 18% of females—migraines (J)
- 8% of males—migraines (J)

The few studies available indicate that 5.3% of 15 year olds have migraines, with 60% of them being male. The numbers for tension headache are obscure due to poor definitions, the many restrictions on studies, and the multifaceted nature of headaches.

A tension headache is located in the temple area and is generally described as an aching or dull pain, sometimes throbbing. It can be mild, moderate, or severe. It is usually bilateral, but it may be unilateral. The headache is associated with increased Temporalis tenderness. (Q) It may be responsive to some NSAIDS, muscle relaxants, and anti-anxiety meds. The tension headache can respond to hot compresses, massage, relaxation, sleep, an occlusal orthotic, PT, stress management, and cognitive therapies. It does not respond to sumatriptan, anticonvulsants, or beta blockers as does the migraine.

In contrast, a pediatric migraine is usually frontal, vertex, or occipital in location. Typical descriptors are throbbing or pounding. The migraine is common to only one side, but it may switch sides. The migraine is usually severe, but it may also be moderate. The migraine is associated with depression. (RR) It also has a strong genetic

relationship to family of origin. (NN) Migraine may or may not present with a visual warning. The pediatric migraine has a more rapid onset and shorter duration than its adult counterpart. (JJ)

Many use the unilateral nature and severity of a headache as a determinate of a migraine, but this is not the optimum choice of symptoms on which to base a migraine diagnosis. The tension headache may also present as unilateral, severe, and throbbing just like a migraine. Tension headache may cause nausea in severely painful cases, but it is not common. Neither common migraines (the most frequently occurring migraine) nor tension headaches have a visual warning at the onset.

The tension headache is more common. A child's description of a dull, aching headache hints at a tension headache. With tension headache's association to stress, a headache during school exams is a clue. The conservative treatment for the tension headache is a reversible therapy. A treatment modality is not chosen based on this aspect alone, but it is comforting for a parent. Migraine meds could be considered if tension headache therapies are unsuccessful. The current approach has been that after *all* migraine therapies have failed, then tension headache treatment may be considered as a possible avenue of care. It concerns me that there is continued patient suffering with each failed drug trial and loss of precious time. When clarity of the headache is available, it seems logical to begin treatment for the tension headache due to its benign nature, conservative approach, and high probability of success.

### **Headache Causes:**

New research has identified the cause of the headache as neurogenic inflammation or inflammation chemicals. Inflammation chemicals create the pain associated with tension headache, trigger the pain associated with migraine, and lead to increases central sensitization. These chemicals are generated by many different sources such as muscles, allergic and environmental chemicals, bacteria and viral invasions, food additives, yeast infections, normal tissue function, and many other sources. The largest source of inflammatory chemicals comes from the head and neck

structures. The single largest source of inflammation comes from muscles (XX), the force behind the action. The muscles of mastication and the cervical muscles are the largest contributors. Other sources provide some additional inflammation.

The things located in the area where a tension headache occurs are: the skin, the Temporalis muscle, and the skull. Since the Temporalis is the only working component in this area it stands to reason that this is the source of the inflammation. One of the reasons it has been so elusive is that a muscle requires multiple demands to exceed its adaptive capacity and each person has different adaptive capacities.

It is not difficult to imagine the muscles of mastication as a major source of inflammation chemicals because of all the various functions performed by these muscles. Lactic acid is the by-product of this functioning. The lymphatic system is activated by muscle function to remove this waste. Increased muscle function produces increased lactic acid. Conversely the lymphatic system is not activated by the static contraction of a muscle such as with tension, posturing, and clenching. The lactic acid produced by the mastication muscles seeps into the carotids and may overload the brain's toxin receptor. The inflammatory chemicals of the cervical muscles seep into the vertebral artery. This multi-sourcing of chemicals from the head and neck region can create a toxic brain overload.

This toxic overload activates a protective receptor in the brain which causes the dilation of the vasculature and initiating pain. There is quite an array of inflammatory chemical sources in addition to the joints and muscles; such as bacteria, viruses, and fungi from the mouth, ears, and nose. Sensitivities to environmental factors, chemicals, foods, smells, cosmetics, and etc. are added into this "inflammation mixture". There is a breach in the toxin receptors in the vasculature and the brain due to this multi-source, continuous bombardment.

This increase in inflammation chemicals from a variety of sources, in large enough quantities, and sustained long enough may cause the body to begin sensitization to the pain stimulus. The chemical inflammation and the pain cause the

body to become more sensitized to the same stimulus, more reactive to stimuli not usually reacted to, or sustain a longer reaction to the insult. (YY) There are volumes of research on central sensitization from pain and inflammation. This explains why headaches are more likely to recur after a patient encounters the first one.

### **The Orofacial Pain Specialist:**

The fairly recent introduction of an orofacial pain specialist has created a new option for referrals by both primary care physicians as well as specialists. This creates a ripple in well-established referral patterns. Ordinarily, patients with severe headaches are referred to a neurologist. The neurologist is superb at diagnosing and treating migraines; but training is lacking in the tension headache arena.

In the past, medicine and dentistry had never really needed to work closely together in order to relieve a patient's pain. However, with an understanding of neurogenic inflammation as the basis of tension headaches and as one of the major sources of inflammation for migraines, new relationships will begin to emerge. Now medicine and dentistry must work together because the tension headache cannot be resolved by just the dentist, the MD, or the neurologist.

It is not uncommon for an orofacial pain specialist to be the 7<sup>th</sup> doctor to see a child that has been suffering with headaches. Referral patterns and communication lines need to change to allow a more efficient and effective use of medical resources.

### **Sources of Inflammation:**

In children, the inflammation can result from different activities, sources, and causes. It is important to note that any one of these activities can exist without enough inflammation to cause pain. If the body's adaptive capacity is adequate, inflammation production is low, and if the activity involves movement, the body can handle the lactic acid produced.

- Normal Function: Muscles produce more inflammation than any other structure with damaged joints being a close second. During normal functional activities there is enough

movement involved to maintain adequate functioning of the lymphatics.

- Parafunction: Nearly 2/3 of tension headache sufferers present with clenching or grinding as an aggravating factor. (T) Nearly 60% of the adult population clenches and 10% of them grind their teeth (M). In children, 25% were bruxers in a study in 1981. (K) Clenching and grinding increase in children with allergies showing both direct and indirect associations with inflammation factors. (CCC) Habitual activities unnecessary for life are termed parafunction. This includes repetitive or posturing activities creating both muscular and joint inflammation. Any parafunctional activity will negatively affect the temporomandibular complex. For example, clenching places the teeth into maximum contact during focused activities. Clenching holds muscles statically. Clenching creates more damage to the mastication muscles than tooth grinding does. (OO) Smaller movements inflict greater damage. Some parafunctional examples are: tooth bracing, tooth tapping, tongue biting, cheek biting, lip biting, nail biting, and muscle bracing. (M) This greatly increases the lactic acid production in the mastication and Temporalis muscles and deactivates the lymphatic system, thereby creating the tension headache. Ignoring this aspect of behavior is one reason tension headaches are so prevalent in children.
- Poor Bite: The mouth operates either efficiently or inefficiently. When chewing, a patient with a poor bite uses more energy, and produces more lactic acid than a patient with a good bite does. The bite gradually changes over time, partly as a result of restorative care among other factors, creating increased inefficiency and headaches. (ZZ) By sleep and EMG studies, five patterns of a less efficient bite have been determined. (O) The three most prominent factors that decrease efficiency are: lack of anterior guidance, posterior interferences, and missing teeth (P). Anterior guidance is the disclusion of the posterior teeth in any lateral or protrusive movement. Children lose their anterior guidance either by

natural exfoliation of teeth or neglect requiring tooth amputation. When proper disclusion does not occur, the power vectors associated with chewing increase dramatically, producing increased lactic acid and inflammation. The relationship between bite and headaches is illustrated by a study of 33 patients with tension headaches that are treated with 4 weeks of orthotic therapy, 64% had a reduced number of headaches and 30% had complete remission of headaches. (CC) Orthotic therapy idealizes the bite.

- Stress: Increased stress creates increased tightness or discomfort in a muscular system. (DD) The high prevalence of tension headaches constitutes the major portion of recurrent headaches. (Z) Tension headache is associated with stress, but it is an aggravator and not the cause. Stress can increase existing pain or be a pre-existing factor for tension headache pain. (QQ) A child that is driven and perfectionist may habitually increase their muscular tension. Today's children are under more stress with end of grade testing, broken homes, peer and social pressures, the teen years and our mobile society as contributors. Some family and school environments can create a great deal of tension for a child. (EE) Personality styles or "empty love tanks" can set the stage for perceived stress. Perceived stress creates contraction of smooth muscle attached to the muscle spindle. This is a static muscle contraction. The adrenalin released causes anxious feelings, degrades sleep, decreases digestion, and produces irritability and cognitive impairment. Children may even be mislabeled as "ADD" because of the excessive adrenalin manifestations (fragility, poor focus, cognitive impairment). For a child with ADD there is increased stress already because they are "different". Around age 10, a child's school environment becomes more demanding. All of these factors combine to create increased muscle tension, increased lactic acid production, decreased lymphatic function and ultimately increased inflammation.
- Posturing/Cervical Involvement: Neck pain affects almost 43% of the population with

48% of this group being female and 38% of them being male. (W) Overall, the groups with the worst posture are children and teenagers. This can be seen with everyday activities such as computer use, driving, holding the phone on the shoulder, poor standing and sitting posture, poor sleep posture, and poor sleep equipment. If poor posture becomes a habit, this daily and repetitive muscle activity will produce increased amounts of lactic acid. Postural considerations are often overlooked by the dental profession. (V)

- Bracing: Contraction of the neck muscles increase activity in the chewing muscles. (VV) The neck muscles brace against the chest and chewing muscles to function. This bracing creates static contraction in muscles to sustain activity in other regions of the body. The amount of contraction decreases as the distance from the area of function increases. For example: the back is less affected than the shoulders when the neck contracts to hold a phone on the shoulder. Cell phones are quite small and tend to exacerbate this type of neck contraction.
- Physical Trauma: It seems logical that direct trauma to the mandible would be more likely to damage ligaments and joints in the craniofacial region, but it is generally whiplash injuries that set the stage for ligament damage in the neck (AA) and TMJ's. (BB) The result of this type of force is usually ligament tearing and joint disc hypermobility. A loose, floppy disc in the TMJ creates increased inflammation.
- Joint Damage(muscle splinting): As the joint ligaments become more torn, the surrounding nerves sense the damage and create a healing response. The muscles around a joint will splint in order to immobilize the injured area. This is called muscle splinting (based on Hilton's Law). Muscle splinting influences healing. However, it is almost impossible to immobilize the temporomandibular structure. Immobilization would mean no eating, talking, kissing, or any other activity that uses the structures of the chewing system. There are mixed signals from the brain. One signal is that the injured part must be allowed to rest and heal and the other signal is

that it is a necessity to use this injured area in order to sustain life. This diametrically opposed muscle activity creates increased inflammation in the chewing muscles. This is why nearly 70% of patients diagnosed with TMD are reported to also suffer from headaches. (U) Another study reports that 64 of the 100 test subjects with articular disc dysfunction had headaches. (BBB)

- Being Female: As you know, the mast cell is the body's "inflammation cell". These cells aggregate around areas known to have frequent inflammation. Mast cells degranulate in the presence of inflammation. The overuse of a structure or trauma to a structure causes the mast cells to release inflammation reaction chemicals (i.e., histamine, bradykinin, prostaglandins, etc.) Science indicates that being female is a predisposing factor to having headaches. This is because a female has estrogen receptors on her mast cells. (D) When estrogen couples with this receptor the cell wall weakens. Masticatory mechanical sensitivity increases ovarian hormonal cycles. (B) This increased cycling means that there is increased mast cell chemical release over a period of time. In a study where rats were restrained, it was found that a female releases 70% more inflammation reaction chemicals than the male rat. Thereby producing increased inflammation. (S) In the laboratory, females show greater pain sensitivity than males (E) Most females experience changes in headache frequency at puberty and menopause. (C)
- Jaw Bite Vs. Tooth Bite: If tooth bite and jaw bite are different, it creates an increase in chewing muscle activity. Teeth erupt in a neutral position (all forces being equal) and then stop. After eruption, the brain quickly memorizes the contraction pattern to offer protection for the teeth. The teeth are designed to control muscles which set the stage for the "tooth protected" bite. Receptors for muscle control are on both sides of the joint. Unique to the jaw, the muscle control receptors are in the Masseters, Temporalis and Medial Pterygoids, but not the Digastrics because they are around the teeth. The tooth bite is not always the same as the jaw bite. On

average, the difference between these two bites is 0.6 mm. A greater difference creates muscular recruitment in an attempt to protect the teeth and the joint at the same time. (PP) When the tooth bite is different than the jaw bite, the mandibular condyles are pulled anteriorly and downward. This pulling of the condyles on the sloped surface is a static contraction which produces more lactic acid than is produced with normal muscular use. The Temporalis then becomes the area where much lactic acid is "hidden".

- Environmental or Nutritional Sensitivities: Many headache sufferers know from experience that red wine, hot dogs, cheese, alcohol, and other food substances may trigger headaches. (SS) Some also have chemical sensitivities and recognize these as contributing factors to their headaches. This type of sensitivity typically does not cause a full fledged allergy attack but it sets up micro inflammations in the bloodstream. Some produce much inflammation and others very little, but when added to the other sources of inflammation it can be overpowering to the body's ability to handle the inflammation. There is a blood test that determines the specific "micro poisons" the patient's body is sensitive to. (UU) Environmental and chemical factors need to be assessed in children with complex and complicated histories and symptoms.
- Significant Stressors: It has been determined that there are two pathways to the sympathetic system by way of the brain. The upper highway, is through the normal route of spinal cord, thalamus, brain, and then the sympathetic system. (TT) All stressors are processed by this method making them susceptible to mental control if one chooses to and learns how to control them. The lower highway is for impulses related to a threat for survival, perceived dangers, or intense intrusions into one's life. These impulses go from the spinal cord, to the thalamus, then to the sympathetic system. One does not think about these factors and often does not even know they exist because they have been buried deeply in the subconscious. In fact,

only a fragment of the original setting has the ability to set off the impulse to the emotional centers of the sympathetic system. It may be a sight, sound, smell, look, situation, or any part of the original insult. These factors can be emotional, sexual and/or physical abuse, abandonment situations, endangerment, or any situation a child deems life threatening. The lower highway stores the needed information in this system because of the need to react more quickly than the brain can react. It also makes it very difficult to determine and manage the “hidden” up-regulators of the sympathetic system. These factors have been found to be an influencing factor in tension headaches. (WW) It is also known that the emotional center associated with this phenomenon is larger in females.

- Miscellaneous Factors:

- 1) Depression: Headache is more significant in girls with depression and anxiety disorders. (JJ)
- 2) Sleep Disorders: beginning at age 3 was a strong predictor of headaches. (KK)

As described, the overuse of the temporomandibular complex and the cervical complex produce the majority of the inflammation. The inflammation chemicals in the blood set off the “migraine generator” that attempts to maintain homeostasis. Once the threshold of the “migraine generator” is breached by the chemicals, vasodilation occurs in an attempt to rid the brain of the toxins. As you know, pain nerves are located in the blood vessels and a sudden vasodilation containing a blood bolus is painful. Everyone has a different threshold. A child may be migraine sensitive due to a low inflammation threshold and serial attacks may lower the threshold. Other sources of inflammation are the body’s defense systems. The head contains the majority of the body’s orifices (where defense mechanisms are concentrated), where it is under constant attack from an array of infections and allergens initiating the inflammation chemicals. The complex interplay of all these activators sets the stage for a painful Temporalsis. The complex array of all the inflammatory sources in the head region set the stage for a migraine.

## **Pediatric Tension Headache Management:**

Diagnosis is the most important part of any treatment. The diagnosis and treatment of tension headache requires medical/dental cross-training. Because a tension headache involves the muscles of mastication, the TMJ’s and the bite, a dentist is needed for the complexities, intricacies, and detail of the chewing system. Because tension headache involves an orthopedic structure, an MD is needed for the complexities, and intricacies dealing with the physics of the structure. Medical knowledge is vital due to the complex involvement of the neck in relation to the jaw muscles, stress and. In order to effectively manage a tension headache, the treating professional needs training in both the medical and dental sciences. This need has given birth to the establishment of an orofacial pain specialty. An orofacial pain professional receives post doctoral training in advanced research and understanding of all causes of neurogenic inflammation. By understanding neurogenic inflammation, we now have the tools to reduce the severity, intensity, and duration of headaches even in your youngest patients. Additionally, by controlling much of the neurogenic inflammation that sets off a migraine, we even get a reduction in a migraine’s severity, frequency, and duration.

The therapy typically takes two to three months of patient effort to reduce or eliminate inflammation in the neck and jaw. It requires a team of health care professionals to guide, coach, teach, treat, and manage all of the factors contributing to the tension headache. The team members are trained in orthopedic principals with specialized training in the neuromuscular system of the jaw and are chosen to help reduce every source of inflammation. The team usually consists of an orofacial pain specialist, a physical therapist, a biofeedback clinician, and the primary care physician, but for some patients other professionals may be necessary.

- Physical Therapy: PT has long been used for orthopedic problems. It has also been proven to be highly effective for inflammation problems in the masticatory system. (DDD) As a general rule most PT’s are well trained to treat areas from the neck down. However, due to the complexity of the inter-relationship between the masticatory system and the cervical area specialized training

in these areas is required. A variety of modalities are used, such as: ultrasound (GGG), trigger point therapy, heat, ice and stretch (FFF), iontophoresis, TEN units (HHH), and phonophoresis to aid in removal of inflammation and promote healing. Patients receive training for proper posturing (EEE), better use of muscles, stretching therapies, joint mobilization, and home exercises to improve muscle function.

- Biofeedback Therapy: Relaxation training and biofeedback were found equally effective as an adjunctive treatment for tension headache and migraine (ZZ). An EMG biofeedback machine is used and is virtually a “tension lie detector”. It gives the child a view into their body to see how much tension resides in their muscles. This aspect of the team assists the child in learning the relationship of muscle tension to inflammation.

- Medications: An injured orthopedic structure requires medications for 2—3 months to allow healing. Typically the medications used are anti-inflammatories and muscle relaxants. Regarding medication concerns: use is short-term (2—3 months) and the meds chosen are for maximum impact, and little interference in the child’s life.

- Muscle Relaxation Device: This is the aspect which needs the orofacial pain specialist most because it requires an understanding of both the orthopedic structures (medical) and chewing system structures (dental). The muscle relaxation device is primarily worn at night to reduce the recruitment of muscles for parafunctional activities. The power of the chewing muscles is reduced as well as reducing the intra-articular pressure. When intra-articular pressure is increased, the flow of nutrients into the joints is decreased and it also destroys the lubricant causing tearing of the ligaments. Intra-articular pressure cannot increase to damaging levels with an orthotic device in the mouth. An orthotic was 87% effective in relieving tension headache in a study in 1960. (AAA)

- Other:

- 1) Sleep: Many times sleep has been disturbed by pain and requires therapy.

- 2) Counseling: In some cases, the lower highway is activated frequently due to significant past events. These need to be identified and addressed.

- 3) Exercise specialist: To develop the best cardiovascular program

- 4) Nutritionist: When food, additives or environmental aspects are a component of the headache profile.

Please note that all the modalities used for tension headache therapy are conservative and reversible. Reversible treatments do not cause permanent, or irreversible, changes in the structure or position of the jaw or teeth. This should allay any fears a parent might have.

The treatment process begins with the collection of information from the child and parent(s) by a pre-exam questionnaire. Detailed historical and clinical information are needed to complete the diagnosis. “The way Dr. Yount interviewed Jamison,” said Ruth, “I knew that he was right on. ... She is usually so shy, but she had no reservations opening up to him because he asked her questions that let her know he was understanding her and taking her for her word.” The child experiencing the pain is included in all interviews and communication.

The orofacial pain specialist truly offers new hope for children suffering from headaches. Now 12, Jamison, continues to do very well. “She has never once resisted wearing her mouth splint. She is so happy to wake up without a headache that she loves and relies on the splint because she knows it helped get her well.”

Orofacial pain specialists are trained to treat and coordinate the care of patients suffering from tension headaches. As the referring doctor, it is nice to know that safe and effective treatment exists for pediatric headaches. The parent and child no longer have to feel hopeless or helpless. Your patient can be happy and no longer held in the painful grip of tension headaches.