Headache and posture

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"I have such a headache I could go crazy…"

Since the first years I worked with the postural techniques of Mézières Method I realized that treating neck problems, such as cervical pain, arthrosis, problems of the temporomandibular joint, shoulder pain, etc., headache problems tended to decrease in intensity or frequency, in some cases even disappeared.

Of course, twenty years ago, there were not the same advanced techniques as the ones modern Posturology uses today, so the connections between musculoarticular pain, posture and headache were not always clear. The results that can be reached nowadays on headache with Posturology are great. An important contribution to the research and advancement of these techniques comes from ***Centro Cefalee of Policlinico Umberto I in Rome*, directed by Dr. Francesco Di Sabato with the collaboration of Dr. Donatella Impieri.** She is a kinesiologist and a posturologist who, in case of tension-type headache, uses a global approach postural re-education with Pancafit®.

Headache represents one of the most common indispositions affecting people. It is estimated that 90% of the population suffers from headache at least once a year. Sometimes, headache comes occasionally, but often it reveals so frequent and severe that it compromises physical efficiency, working ability, family and social relationships, and so life quality.

The main types of primary headache, as Dr. Di Sabato explains, are: **migraine**, **tension-type migraine** and **cluster headache**. Any of them can be recognised by a specialist through an accurate anamnesis, including a description of pain, its position, related symptoms, behaviour during the attacks, duration and frequency of the episodes. Migraine affects a huge part of the population and, even if it hits young people as well, it is more common in middle-aged persons (18% of women and 6% in men). Migraine divides into two forms: **migraine with aura** and **migraine without aura**. In the first case, the pain is mainly unilateral, even if it can change side or be bilateral as well. It can have moderate or severe intensity. It is characterised by a throbbing pain that gets worse with movement and it is often

associated with nausea and vomit, aversion for light and noises, and in some cases smells. The patient usually needs to stay in bed in a dark and silent place. Attacks can last from 4 to 72 hours. In with aura form, the painful phase is preceded by focal neurological signs appearing gradually and going on for 10-20 minutes up to 60 minutes. The aura entails visual problems such as photopsia (seeing lightning flashes), objects deformation, hemianopsia (decreased vision in half the visual field of one or both eyes). In some cases there can be sensory conditions, such as numbness of arms and legs where the pain is, aphasia (alteration or loss of the ability to speak and understand written and spoken language), or cases in which the patient says something different from what he wanted to say, sometimes even incomprehensible words. There is then a headache which can have typical migraine characteristics plus different ones. Crisis with aura are much less frequent than the ones without aura but both types can affect the same patient. A migraine diagnosis is possible when at least two episodes with the same features are registered. When there is no painful phase, it is a case of migraine aura without migraine", unless it is a sharp cerebrovascular episode.

It is very important to investigate on the possible favoring or triggering factors related to the attacks; for instance, specific foods, variations in life rhythms and sleeping habits, stressful events, connections with menstrual cycle. It is known, in fact, that almost 60% of women affected by migraine without aura suffers attacks especially during premenstrual period and 10% has attacks only during the days preceding the cycle or during the first days of the cycle.

Another type of periodic and predictable migraine is the one that occurs at the end of the week, i.e. the so called *weekend headache*. It is important for the posturologist to know that almost 90% of the headaches are tension-type migraines and of these, 75% of the victims are women. It can be infrequent (less than one crisis a month), frequent (from one to less than fifteen crisis a month), and chronic (more than fifteen days a month). The diagnosis can be made when at least ten attacks happen showing these features: constraining, bilateral, middle-intensity pain (not affecting normal activities); associated symptoms are usually absent or there can be a moderate photo/phonophobia. Pain does not worsen with movement. The duration of the attacks goes from half an hour up to seven days. In the lighter cases, it is often related to stressful periods. In the worst cases, pain will appear in the morning and continue till night.

Cluster headache is instead a rare form, talking from an epidemiological point of view: it affects 0.5% of men and 0.1% of women. Although it is a typical masculine problem, recently there has been an increase in occurrence in women, due to changes in working and life styles. Attacks are extremely painful, to the point that people speak about **suicide headache**.

Cluster headache is characterized by short episodes of stabbing, middle-intensity pain that can last from 15 to 180 minutes and involve orbits and/or temples, usually unilaterally. Typical of cluster headache are intense weeping, red eyes, nasal obstruction, rhinorrhoea, facial sweating, all these on the same side of the pain. Attacks occur daily, often at the same time, once or more in a day for three to six weeks periods a year. 10% of the patients has a chronic form, without long pauses from one attack to the next one.

The intensity of the pain is so elevated that the patient feels the necessity to move constantly (running-walking) and to find a comfortable position. Moreover he/she does not stand the presence of other people around.

In the Centro Cefalee of Policlinico Umberto I, thanks to Dr. Di Sabato, was possible to reach a cooperation among doctors, psychologists and posturologists, with notable results in cluster headache cases. It was possible to observe that 95% of the people affected by cluster headache presents a wrong posture.

Dr. Di Sabato and Dr. Impieri assert: “Through the Raggi Method® with Pancafit®, patients become first of all aware of their body with breathing and relaxing exercises for the back and especially the cervical district. The number of sessions can vary according to the seriousness of the cluster headache. At the end of the sessions, almost 80% of the patients experience a reduction of the attacks, in terms of duration and intensity. 98% of the patients are more aware of their body and more able to react to future attacks. **Almost 80%** after at least two sessions of work with Pancafit® **completely solves the headache**. This collaboration is therefore leading to enormous results.

THE CLINICAL CASE

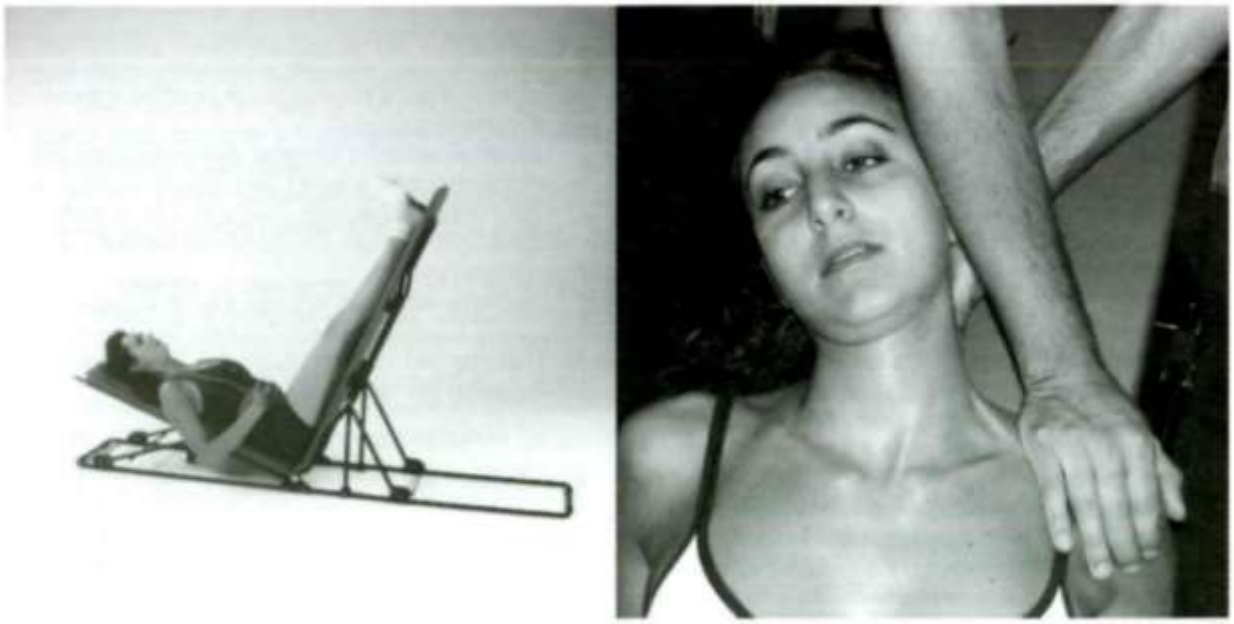
Now, I want to introduce you a real case to let you understand better the relationship between cluster headache and posture. Mr. Marco C., a 38 years old textile worker, came to our studio for a neck problem. He also told me that he suffered from terrible headaches. Collecting information about his personal history, it came out that the headache was the worst pain he had ever experienced; it forced him to stay home from work and lock himself in a dark room, without speaking or seeing anybody. This

happened especially when he drank alcohol or ate very late at night, after going to the disco, and anyway once every ten days. Compared to it, his neck pain was nothing.
Given his description of the headache, I did not say anything about possible results or solutions, but I started thinking about the neck. The patient was quite athletic, balanced and had a decent posture. The only negative point was the right knee, which appeared to be lightly internally rotated, even if the patient did not remember any trauma related to it. We started the first session addressing to neck and breathing, always keeping a correct posture and working on the posterior muscular chain, which connects the whole body, from head to feet.
During the second session, the patient told me that his neck pain was improving, even if it was moving towards his back. I repeated the same kind of exercises and maneuvers, this time focusing even more on the breathing.
By the third session, the pain in the neck had reduced by 50%. The patient had an attack of headache, but its intensity had considerably reduced. However, an old pain in the lumbar zone appeared again, after having disappeared for four years. I told him not to worry, since we were on the right track, and explained him that the pain came back for some days because it was an old pain which had never been completely solved. The body had hidden it and “made it move” towards the neck.

The following time, the patient came to me with some very interesting news. During the week, the pain had moved from the lumbar zone to the slightly rotated knee, making him remember that five years ago he had had a sharp pain in that knee which had lasted for a couple of months, then it had gone away even if he had continued playing soccer. What was most surprising was that the pain migrated from the right knee to the right ankle. That pain in the ankle made Marco remember an episode he had forgotten: seven years earlier, he suffered from a serious sprain in that ankle playing soccer, and it took a lot of time to recover from that condition, which forced him to limp for a long time and to keep the leg slightly rotated in order not to feel pain. In this way, the pain, which resulted **compensated** by the **antalgic attitude** of the body, moved towards the knee, the hip, the back and the neck, transferring the tensions to nape and cranial muscles.

We can therefore conclude that that trauma was the hidden cause of the headache; as a matter of fact, after having treated and unblocked the ankle, the patient did not suffer from headache attacks any further. That headache was the result of very deep tensions that the body had produced in order to defend itself from the pain in the foot and the knee involving the whole muscular chain.

We can therefore state that what is not solved, even if cleverly hidden by the body, remains unsolved.



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