Chronic Myofascial Pain and Headache
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Introduction

Chronic myofascial pain and benign headache (cephalgia) syndromes warrant special mention because they do not fit neatly into the three mechanism (somatic, neuropathic, or psychological) categories. Chronic myofascial pain and benign headache may accompany recovery from catastrophic injury or arise independently. These symptom complexes rank among the most common reasons for seeking medical treatment. Gender may exert a prominent role in prevalence, symptom presentation and response to therapy. Women are five times more likely to experience myofascial pain and up to seven times more likely to experience benign headache than their male cohorts (Rasmussen & Jensen, 1994).

Chronic Myofascial Pain

Chronic myofascial pain is diagnosed when pain, stiffness and other associated dysfunctions arise from muscles, ligaments and fascia. Scientific literature cites several synonyms for "chronic myofascial pain" including fibromyalgia, fibrositis, idiopathic myalgia, diffuse myalgia syndrome, muscular rheumatism, psychogenic rheumatism, nonarticular rheumatism and interstitial fibromyositis (Rowlingson & Calader, 1996). Associated conditions include sleep disorders, diminished libido, irritable bowel syndrome, depression, tension-type headache, temporomandibular joint (TMJ) dysfunction, diminished mental acuity (“fibrofog”) and chronic fatigue. Pathophysiologic origins of the myofascial pain symptom complex remain uncertain. Since no definitive diagnostic studies exist, diagnosing chronic myofascial pain must be made by excluding diseases with similar presentations, *i.e.*, myopathy, hypothyroidism, tendonitis, bursitis, overuse sprain/strain syndromes, polymyalgia rheumatica, temporal arteritis and various forms of arthritis. Treatment strategy remains interdisciplinary and focused on movement, manual therapies, relaxation training and functional restoration. Anti-depressant and steroid medications are frequently used to supplement response to restorative activity. Chronic opioids, corticosteroids, nonsteroidal anti-inflammatory drugs or muscle tone modulators may be helpful anecdotally but they have enjoyed little evidence for efficacy. They are often reserved for periodic therapies or highly problematic cases (Fisher, 2002; McCain, 1988).

Headache

Benign headaches are categorized into five broad groups:

a. Migraine- with or without aura, ophthalmic, retinal, childhood periodic, complication of migraine, transformed,
b. Tension-type- episodic <15 days/month, chronic> 15 days/month
c. Cluster- cluster, benign paroxysmal hemicrania,
d. Miscellaneous- head trauma, vascular disorder, nonvascular intracranial disorder, withdrawal cephalgia, trigeminal neuralgia, and
e. Deafferentation- denervation perception with pain.

Accepted mechanisms for migraine (Headache Classification Committee of International Headache Society, 1988; Lipton & Stewart, 2001), tension-type (Bolay & Reuter, 2002) and cluster headaches (Jensen, 1999) are the basis for current medication-based prophylactic and abortive cephalgia treatment protocols. Chronic headache management is optimized in an interdisciplinary setting. Psychological assessment and therapy concurrent to ongoing medical care consistently amplify recovery and response to intervention. Manual, physical and complimentary therapy regimens also benefit cephalgia sufferers.

References