Academy of PHYSICAL MEDICINE

Transcript

Headache Management With Elizabeth Huzzey

Cast List

Steven Bruce	SB
Elizabeth Huzzey	EH

SB: This evening, we're going to be talking about headaches. I have with me Elizabeth Huzzey. Elizabeth has been studying headaches for a very long time. She's an osteopath. She is a founding member of the Osteopaths for Progress in Headaches and Migraines organization, about which we'll hear more later on. She is studying for a masters in headache management, and I got that wrong but she'll tell me about that in a minute, at the University of Copenhagen, and she is the only manual therapist on that course. The rest are neurologists, which is an interesting connection. She has strong connections with the NHS and what they've been doing about headaches. She has also strong connections with organizations called BASH and OUCH, about which I know very little. Elizabeth, welcome. Great to have you here.

EH: Thank you for having me.

SB: Tell us first of all about the thing in Copenhagen. Great to do a master's but you're there with a bunch of neurologists which is quite extraordinary.

EH: Yes, it's a great a master's to do. University of Copenhagen is world renowned for its headache center, the Danish Headache Center, and they set up this master's two years ago. This is the second time they've run it. It's primarily for a master's purely for headache disorders.

SB: Did I get it? I said headache management. You said disorders. I got that wrong. Just after you corrected me, well ... How do you fit in with the neurologists?

EH: Fine. They're very open minded. I'm not the only one. There is one other physiotherapist from Latvia. People come from all over the world. We've got people from America and from Pakistan and everywhere in between. I would say probably out of 22 of us, 17 would be neurologists. There's a couple of headache nurses, a physiotherapist and myself.

SB: Aren't the aims slightly different? The neurologist wants to know about drugs and surgery, whereas the rest wants to know about what we can do in clinic.

EH: It's not really geared towards treatment strategies as much as understanding the science that comes behind headaches with a view to try and encourage evidence-based research.

SB: About which we're going to hear quite a bit in a few minutes time. I talked about two other organizations, BASH and OUCH, which I think is the British Association for the Study of Headaches, and the Organization for the Understanding of Cluster Headaches. What's your connection with those?

EH: I first became a member of BASH about nine years ago. It's when I was starting to want to find out a little bit more about headaches to answer questions that I found myself in clinic. At the time, it wasn't very easy to find those answers. I came across BASH, and their mission statement was to include anybody that wants to improve treatment and understanding of headaches, so I became a member. They're a very useful organization. They're very welcoming. It's mostly medics again.

SB: Which is very handy, isn't it, because if nothing else, it helps us to understand them and more importantly, them to understand us.

EH: Absolutely.

SB: I said that you were a founder of the Osteopaths for Progress in Headaches and Migraine, but I also know you've worked with a lot of multidisciplinary teams, which include chiropractors. A lot of our audience are chiropractors too. How do you find the different approaches between the two?

EH: Well, I haven't actually worked with chiropractors, but when I was starting again this journey of trying to understand, it started off with me actually experiencing what turned out to be vestibular migraines, but that wasn't diagnosed for a very long time. I was looking for education and understanding of the dizziness side of things as well. I went to the Bournemouth College. They ran an excellent course, which I don't know whether they still do, it was run by a physiotherapist on the vestibular aspect,

which is not headaches per se but they're definitely into linking and sit side by side.

SB: Your interest in headaches goes back how long? Your practical investigation into treatment of headaches rather than having-

EH: Not headaches. Historically, I wasn't a headache sufferer, but I had a couple of head injuries and those things. My curiosity really came, I've been practicing for 20 years, and anybody out there that knows about practicing, you know that you have some apparent ... you seemingly have some great results with some patients with headaches, and others don't seem to respond. The start of my journey came straight from the clinic room while trying to say, well, why do these people respond and these people don't and what's the difference? Am I missing something? Am I missing something serious and sinister with these patients? What's actually causing the headaches? If I can't treat them or what I'm doing is not being effective, why is it not being effective, and are there more appropriate treatments out there?

Really, the curiosity came from really from the clinic room. I wanted to be able for a patient to walk through the door and be able to know that I was going to be safe, that I would be able to make a defined diagnosis. I'll be able to explain to them what was causing their headache, and I would be able to give them their treatment options. If one of those options was my treatment, I would be confident that I had a good chance of doing best practice. That's where it started.

SB: You do lots of lecturing now. Who do you lecture to primarily?

EH: I wouldn't say I do lots. My teenage children may see it differently. We've started to ... Through the OPHM, the osteopathic, our little group, it was just four or five people that came together having seemingly been on the same journey, and we happen to come across each other. We're all very much on the same page of what we felt that we benefited from and what we thought would help other practitioners, other osteopaths, other chiropractors, physios in a clinical setting. The lecturing I do is headache days through with the OPHM team. That's at UCO. We're doing twice yearly courses there. We've done some regional societies, but it's been evolving over the last few years.

SB: Again, it's the professionals. It's not necessarily to lay people, to the public.

EH: It's not the public. I've done one lecture when Migraine Action was still around. I was asked to go and talk to them and they were patients. They were the sufferers. Primarily most of my lecturing is to help similar people in similar situations as myself.

SB: You talked about safety a minute ago, and I guess that that's something which we've always been concerned about, but I have this feeling that in recent years, it's become more and more of a concern for us, a concern for chiropractors. How much of a problem is it in treating headaches you feel we're ever likely to misdiagnose, to treat something we shouldn't or fail to refer on something that we should?

EH: Well, I think if you don't know the signs, the warning signs, then yes, you're likely ... Trying to put it into perspective. Actually the number of serious headaches is very small. Proportionately anybody that walks through the door, the chances of them having serious causes is very low. I don't want to scaremonger anybody, but if they do, you should know the warning signs. I think anybody that says that they treat headaches on their website or patients come to see them for that complaint, they need to be able to know those warning signs.

SB: What should we be looking out for?

EH: The primary warning signs, there are a few. Mostly, there's no biomarker for headaches now. Most of the clues you're going to find in the case history. You have to listen to the story of the patient, and that's where you will get the diagnosis. Diagnosis of the headache type is primarily in the questions and the story that they tell you. There's a few benchmarks that BASH have said that, which rather than red flags, let's talk about green flags because sometimes that's easier. The green flags being those signs that you can assume or that's the benchmark that there probably isn't something wrong. BASH put it down, they say the six-month rule where if a patient has had headaches longer than six months, the chances of them, and it's not progressing, the chance of it being a serious cause is negligible. That's quite a nice benchmark to use.

SB: Not handy for the patient who comes in with a headache after a week, is it?

EH: No. You have to ask all the other questions.

SB: I guess we would instinctively exclude something where we thought it was the result of head trauma.

EH: Yes, but head trauma, it's not just an immediate head trauma. You can have a red flag for, I think it's three months after head trauma.

SB: If there had been head trauma, I think we would automatically start thinking there could be something more sinister going on.

EH: Yes.

SB: What else? We're looking for, what, for meningitis?

EH: We're looking for people over the age of 50, a new onset headache. It's different from ... You can have people who have had migraines or headaches in the past, but if it's a new onset of a new type of headache, something that they've never had before, particularly over the age of 50, then you definitely need to refer those on for ... You have to assume it's the secondary until otherwise-

SB: Any headache or is this just severe headache?

EH: Any headache? There are other signs.

SB: Just in pursuing that, what might you be thinking could be the cause that requires that referral onwards?

EH: Well, you've got the temporal. You've got the vascular, so temporal arteritis. You've got the acute glaucoma, the GCA, arteritis. Obviously, you've got the slow growing tumors and the vascular TIA's or thrombosis.

SB: It's interesting. When I teach first aid courses, which I do periodically, not frequently but periodically, purely for osteopaths and chiropractors. Of course, when we talk about stroke, we talk about the FAST test, but later on it's mentioned in all that publicity that they put out about headaches that actually severe headache is a potential sign of a stroke, symptom of a stroke I should say. Of course, what you're saying here is actually it could be.

EH: Yes. The big one that everybody listens to is the subarachnoid hemorrhage and that's the thunderclap headache. That's out of the blue, reaches its peak within five minutes and it's severe pain. The chances that somebody is going to be walking into our clinic with those symptoms is relatively small.

SB: It is, except one osteopath I know had a patient come in with exactly that, who then collapsed, not breathing, on his floor, and he and a responder were doing CPR for 20 minutes before the ambulance got there, and the woman died. That's probably almost certain to happen in those cases, I would have thought. It can happen, can't it?

EH: It can.

SB: There is a real danger in perhaps thinking it's very rare, therefore I shouldn't worry about it. As you've said earlier on, we've got to be alert to those rare but significant indicators.

EH: I think the statistics help at all. I think 10% of people that presented A&E with a headache have a serious cause, I think it comes down to 0.1% for a GP. We're going to be below that I would imagine, but you've got to look out for those warning signs.

SB: We talked about severe pain. Meningitis is another one, isn't it? Would that be something which you pick up readily?

EH: You look for high fever. That would be another red flag. If you're looking for general unwellness, another red flag will be cognitive dysfunction so personality changes or just behaving differently. You've got the history.

SB: With the headache.

EH: Yes. Obviously, you don't have to have a headache if you've got a tumor or a neoplasm creating some cognitive function. It doesn't have to come with a headache, but with people who are presenting with a headache, that's one of the things that you would go through, you'd be looking for.

SB: Your protocol for screening headaches, is that something which we could find on the BASH website or is there a protocol for screening to make sure you've excluded all these risk factors?

EH: There is. We're putting one together. We're trying to put one together that's tailor made for osteopaths for our situation, but yes, you can find out red flags on the BASH website or on NICE guidelines, NHS assessments.

SB: You talked about us treating headaches, saying that we treat headaches on our website. The Advertising Standards Agency says we can say that we treat headaches of cervical origin, so headaches as a result of neck problems for the lay person. On your website, you treat migraines.

EH: Migraine management.

SB: You're allowed to say that, right?

EH: I'm allowed to say it because I use acupuncture. That's NICE Guideline.

SB: There's a really interesting problem there, isn't there, because if you're dealing with anybody who does anything other than pure osteopathy, actually there are lots of things which might or might not have evidence for treating headaches. Is the evidence strong for acupuncture?

EH: It's strong enough for the NICE guys to put it in the NICE guidelines 2012.

SB: For all headaches or just migraine?

EH: For migraines.

SB: You did a course in traditional Chinese medicine in China itself, didn't you?

EH: Yes.

SB: Are you a fully fledged acupuncturist as well?

EH: Well, I did two years in China, so I've got some background in TCM and the differential diagnosis. Since I've come back, I've also registered with the BMAS, which is the Medical Acupuncture Society.

SB: Which is where my question was going. Does the ASA, do any authorities accept that dry needling as opposed to acupuncture proper if I can-

EH: I don't think they differentiate as far as I know because I know the BMAS run an acupuncture day for headaches.

SB: Interesting. Our last speaker was meant to be Philip Rose-Neil, who is I think president of the British Acupuncture Council for some time. He had to cry off because his wife was taken ill suddenly at 26 weeks pregnancy. It was a bit more of a crisis than he could leave to just her to manage. It would be nice to discuss that with him when he comes in to talk about the evidence for this and what he thinks are the differences between treating with the limited knowledge that you get from a dry needling course as opposed to the detailed and slightly different knowledge that you pick up on-

EH: Yes. That's why I came across the first classification of headaches, was when I did TCM because they classify it in different types depending on the diagnosis. Whereas, Western medicine at that time was pretty much just headaches. It's now been ... I think they've got ... TCM I'm sure is going to be more in depth and more effective than just I would imagine it would be. At the moment, the evidence put together was by Mike, I believe ... I hope I'm not giving the wrong information, was by Mike Cummings, who's from the BMAS. He does a big acupuncture clinic at the homeopathic hospital in London. He's got big numbers. You've got big numbers. You've got big sample. He's got the advantage of being a doctor and so he's got that research language. He did the studies.

Interestingly, which a little anecdote, is that they found that acupuncture I think was about 75% improvement for migraines, but sham acupuncture was 70% or something. There wasn't that much difference. Topiramate, which is an antiepileptic that they were comparing it to, had far less effect. It was only 50% effective. The placebo was far less. That was statistically more significant. That had more weight than-

SB: What were they using for sham acupuncture? Do you know?

EH: They were just putting it in non points. That's how they put it. They just put needles in random-

SB: Random needles as opposed to some simulation of sensation of a needle but nothing penetrating.

EH: They put needles in but just not in the defined areas that people use.

SB: That's a bit disappointing for those who trained for years in acupuncture, isn't it, but reassuring for all those who have done the rather shorter course.

EH: Yes.

SB: Were they needling in shoulder and neck area?

EH: It's hugely upper trapezius. For people who are familiar with acupuncture, it's the GV 20, 21 and large intestine 4 and little 3. Those are the normal ones, but then that's where TCM comes into it because they can add the depth of the proper diagnosis rather than just trigger points.

SB: I learned my dry needling at the London Homeopathic Hospital, a chap who was a very, very well established acupuncturist himself, and his name escapes me, as names always do when I want to call them to mind. He was quite adamant that in his mind, acupuncture points didn't exist. He called them acupuncture treatment areas, I think, so somewhere in that vague area will be just as effective as this specific point, which perhaps is what's going on with the placebo effect that you were talking about. TCM categorized these headaches into a number of groups. What about Western medicine? We talk about primary and secondary and then different types of headaches within that.

EH: Fortunately, the last 10 to 20 years, the medical community, headache medical community have been developing this international classification of headache disorders in a massive project for them where they have the third ... It is now ICHD-3, which is the third and final. They're not going to revise it again for another 10 years, but they have mostly neurologists where they've classified different headache types. It's a pretty useful tool. The guy who developed it was a Danish chap called Lars Olesen. He designed it so that it could be used in every setting. It could be used in a clinical setting. It can be used in a research setting. The idea behind it is that they want to categorize it so that everybody internationally is using the same language to then do full clinic ample research.

SB: What is the language? Primary and secondary I think speak for themselves. Certainly primary headache is its own origin. Secondary means it's the result of something else. What categories have we got within that?

EH: Primary headaches, the three main primary headaches are going to be tension type, migraine, migraine with aura, migraine without aura, and the TACs, trigeminal autonomic cephalalgias. Under there-

SB: Is that what we would call cluster headaches?

EH: Cluster is the most common, but you've also got SUNCT and SUNA and hemicrania continua and there are lots of other ones.

SB: Right? I'd just run through that again. What was that third category overall?

EH: TACs they're called, the trigeminal autonomic cephalalgias.

SB: Cluster headaches, I can cope with that one. You said SUNCT.

EH: SUNCT.

SB: What is that?

EH: I always forget the acronym. They've changed it now to SUNA.

SB: I thought that was a separate one.

EH: No. That is a TAC. It's a spontaneous unilateral conjunctival tearing headache. I think that's what SUNCT is.

SB: Blimey.

EH: It's a neuralgic pain, but you have to be able to differentiate it between trigeminal neuralgia and SUNCT and SUNA because they often mimic each other.

SB: The secondary headaches would be cervicogenic.

EH: Cervicogenic comes in there. You've got the posttraumatic headaches in there. You've got the medication overuse headaches in there. You also got the ones, the red flag ones so ones due to fever or metabolites or neoplasms or vascular. They're in there of course. You have the ... which ones I'm talking through here. I've just lost my train of thought then.

SB: We can put those up subsequently for people to look at. We'll have them on the briefing paper that we produce as a result of this, either because you've told me what it is or I'll have to go look it up myself, which is much harder work.

EH: You can have a look at the ICHD-3. It's actually really useful. They've divided it into five sections so depending on what depth you want to go. Primary care, you need to know your headaches to the number one. If you're going into secondary care, you need to know it to three. If you're going to real tertiary research, you need to know three, four up to five.

SB: We'll make sure that everybody can see that on the website.

EH: It's useful.

SB: We can't escape looking at the evidence because the ASA says that we can only treat cervicogenic headaches. Yet as far as I'm aware, there is some evidence for treating tension type headaches as well with manual therapy. You're the expert. Nobody likes being called an expert. I know.

EH: I'd love anybody to find me something, but at the moment, there is not a lot of robust evidence.

SB: What did I see? There was something by ... I'm just trying to look at my notes here. Kasten, et. al. in 2011 published something about treatments of tension type headaches. I have forgotten the detail of that paper because all I wrote down was the reference. I think it was a cohort about 89 or with some number were lost to follow up.

EH: There's quite a lot of research out there. A really good guy, Cesar Fernandez, who's a Spanish physiotherapist, and he's done a lot of great, really good research. I think he's seeing some evidence between centralization and trigger points and migraine and tension type. As far as robust evidence, generally the number of samples are small. Generally the validity is not great. Generally the ... The scientific and community can definitely pick holes in it.

SB: You can pick holes in any research. I've always wondered just how robust does it have to be to satisfy the ASA that we can say we might have some success with this. Do you have any idea?

EH: I don't. I can't comment on the ASA. I don't know what their criteria is. I'm just talking from the ... It's known across the medical, the scientific. It's really difficult what we do because it isn't a pill that everybody can take the same pill.

SB: Nor is treatment consistent. If you're going to see an osteopath, you don't get the same treatment every time.

EH: Exactly.

SB: Even if they say we're doing, let's take for example, cranial, they may not be treating the same thing just because they're treating cranial. They maybe do something totally different.

EH: Yeah. There's a lot of variables. In fact, the best ... Francesco Cerritelli did a systemic review of osteopathic treatment on headaches in 2017. His findings were he took all the studies, found lots and lots of studies that whittled them down. Again, the samples were small. His conclusion was that there is no robust evidence at the moment, and one of the reasons there's no robust is because a lot of the studies didn't differentiate between the different headache types.

SB: Yes, and I remember that being a criticism of the study I mentioned just now. They didn't differentiate what they're treating.

EH: That's why ... We'll go on to the headache project we will talk about later. That's where we're starting from that platform because for best practice, for research and for diagnostic confidence, you need to be able to recognize the different headache types.

SB: I think the study that they did was what I've learned over recent months is called a pragmatic study. In other words, it wasn't seeking to identify the intervention. It was just saying if we throw a whole bunch of people at an osteopath or I think it might have been a chiropractor, I don't know, but we throw them into chiropractic care or to osteopathic care. How many of them come out feeling better? They didn't worry about what that practitioner did inside the treatment rooms. Is that the way ahead for this research?

EH: I think that's why they're using PROMs. That's patient related outcome measures. There's another one now that NCore are using and lots of other people, which is PREMs, patient related experience measure. I think that's what it is. I think that's what's used because it's so difficult to do it any other way. I'm doing research but I wouldn't put myself out as-

SB: We had Jeremy Howick a few months ago now I think who is at Oxford University. He does a lot of research into the placebo effect. I can't remember his title there, but he's done a lot of work on this. He was specifically saying that more and more people are now turning to pragmatic studies because we aren't a pill, and you can't say that every osteopath treats exactly ... Even if they think they're treating the same dysfunction. It's never one thing in osteopathy or chiropractic, is it, even just treat C2-3. You work on some muscles or you work on some mobilization and maybe you manipulate this or that or maybe a recent cranium as well, depending on precisely what you find in that individual patient and therefore pragmatic study may be the only way.

EH: It is. I think it's one way. I think there are other ways that we can address it. Drummond and Watson in Australia have done quite a lot of research. Watson is a physiotherapist. Drummond is a researcher. They published a paper where using certain techniques on C2-3, they can change ... measure the blink reflex to prove that cervical afferents can desensitize that. They've used ... That is rather than patient experience or do they get better? That's looking at if we do this, that happens. I think we could probably do more of that.

SB: There's quite a lot that I've seen about the whole concept of central sensitization and headaches. Is that a major component?

EH: Yes.

SB: In all headaches? In migraines?

EH: Definitely migraines. Migraines, it's all the engine room is the trigeminal cervical nucleus. Tension type headaches, the same. That's the junction box. If that is hypersensitive-

SB: For what reason?

EH: There are lots of reasons. They're still looking at that. I think their genetic predisposition, it seems that there may be links between whether you're under stress or you have irregular sleeping or there seems to be other things as well.

SB: If you were presented with something like that, we're all attuned now to thinking biopsychosocially, sure, you would ask about other factors, but what are you likely to find in that individual, in that body that might be helping to sensitize that nucleus?

EH: Hypersensitivity to stimulation is generally the sensitive brain or the migraine brain. It doesn't habituate very easy. It doesn't like change very easily. I think there was some study where if I was just pressing on the table like that, a migraine brain couldn't tune out of that. That would just drive them mad because they couldn't adapt to it. If you're looking at little signs and symptoms-

It's if they don't adapt to change in their environment particularly well, so they're not good with sleeping patterns.

SB: Okay. But I'm looking for something that we can influence in clinic here when someone comes in to see us, what would you be looking to change physically?

EH: Oh, physically. Well, we know that their upper cervicals feed into it. So if you can reduce facilitation in those segments, I think there's pretty good connection that you can...

SB: Right.

EH: But it has to be inhibitory. So if any vigorous work, I think there's now quite a lot of evidence that if you do vigorous work in the upper cervicals, you can do the opposite, so you can worsen migraines, you can quantify migraines.

SB: And I was telling you earlier on, before we went on air, wasn't I? The only thing I remember being taught about headaches from my training, which was 20 odd years ago, was C2 is often implicated in headaches therefore you manipulate C2. But is that too vigorous or does it depend on how you manipulate it?

EH: I've yet to find any study to suggest that I've lost the thrust to C2.

SB: Are effective or are ineffective?

EH: If has any longterm efficacy.

SB: Right. Okay. And that's the key, isn't it, too? It's long term efficacy, not just about it might take your mind off your headache for an hour or two.

EH: Yeah. I've yet to see-

SB: In the past, I presume you must have used manipulation before you became so expert and obviously you've seen quite a little headache patients, but you wouldn't use manipulation now or?

EH: It's a great tool. It's not, I don't... The question we always ask ourselves as a clinician, as an osteopath or any, is I've got this tool box of techniques, what's going to be the most appropriate for the patient in front of me? So I wouldn't say never, never, never, but I don't use it a lot in- I think there are other ways-

SB: We've had some questions, been coming in since we went on air. One of them is do you see patterns of neck restrictions in headache sufferers?

EH: Neck restrictions? No.

SB: Right.

EH: Generally I think the upper... I think we all find that the upper thoracics and... so the CT around there is generally restricted, but not always, and it depends on the headache types. Sometimes it's hypermobile, a lot of the migraines with young women they're generally hypermobile. But it's cervical dystonia, it's that stuff, it's not that it's not moving. It's sometimes it's moving too much.

SB: I think I saw somewhere in the research that headaches are a far more prevalent problem in women than they are in men. Is that all headaches or is that primary headaches or?

EH: I think it's been a cluster's... More male dominant cluster headaches is more likely to happen in men. Migraines more likely to happen in women, tension type I think is geared a little bit more towards women as well.

SB: Is there any treatment that you're aware of, is there any research into manual therapy for treatment of cluster headaches? The only thing I could see when I looked into this was drugs, that's the answer.

EH: Yes. I think you owe it to the patient to not treat cluster headache as a primary point of treatment because they are called suicide headaches for a reason. And we know-

SB: Why is that? Because actually, this is old hats to you, but there may be people out there who aren't quite as familiar with cluster headaches as you'd like them to be.

EH: Okay. The cluster headaches come on short period of time, between 30 minutes and an hour and a half duration, and they are severe. And the biggest difference you can tell is if you see a patient with cluster headache, they can't keep still, they're agitated, they're rocking, they're holding their head and grown men are crying out in pain and grown women they're crying out in pain, which is there.

SB: I've seen that women describe it as being worse than child birth.

EH: Yeah. And you will often see some art where they're getting a knife stabbing in the eye. And we know that fast flow oxygen, we know that sumatriptan... fast flow oxygen is very effective to abort acute attacks. And we know sumatriptan injections and needle sumatriptan can be... So there's a reasonable amount of... I've heard criticism amongst the OUCH community where people have been treated by osteopaths and physios and chiropractors and with no effect and inappropriately.

So I think cluster headaches you owe it for them to put them in that direction first so they can... Then if you want to talk about trying to treat their body as a whole or go into, in theory it's to do with the parasympathetics and the autonomic reflex. So there's the lady in Denmark Witmore Jenson, she's pioneered this electro stimulate that they put in sphenopalatine ganglion and they can press that and that can also modulate the pain. So in theory you can see the connection between maybe cranial work or trying to temper with parasympathetics if you wanted to go in a theoretical. But practically I don't think... That's not the place the patient has to come first.

SB: Yes. And I suppose the research presumably has to go down the line of, well, can we find something which seems to prevent cluster headaches? Sorry, yeah, cluster headaches, isn't it? Rather than, can we treat the acute cluster headache sufferer?

EH: Yes, or is there a chronic cluster headache sufferer when there... Is there something possibly that we can-?

SB: Oh, it's the typical pattern then, if someone suffers cluster headaches, are they likely to get them regularly from-

EH: They happen in clusters, that's why. But they're always at the same time of the day or the same time of the night, so there's a circadian rhythm to it. So I

think the hypothalamus is pretty much involved. They will get the tearing of the eye, the autonomic features flushed cheek, red eye. And so they know that the autonomics are involved.

SB: Well, I suppose they happen in clusters, so how many are a cluster, how many might it be?

EH: It can be a piece of string really, you can have it for... There's some evidence that it seems to happen most likely in spring and in autumn, but not always, but they seem to be. And people often will have them from everyday for a month and then they'll go, and then they'll come back again.

SB: And is there any sort of typical interval between them, which is kind of what I meant there? So they could go away for a year or longer.

EH: Their only pattern is seasonal autumn. That's the only pattern they've found. And that's not exclusive, but there's a pattern spring, autumn, and always same time of day or night, and they happen in clusters.

SB: Yes. Okay. Somebody... thank you to whoever this was. If you sent it in, thank you for reminding me that the chap who taught me my needling was Anthony Campbell who still teaches needling at the Homeopathic hospital, I believe. What do you do, I'm asked for hypermobile headaches sufferers?

EH: Oh, I pause. I pause, it's really... For migraine sufferers, migraine with aura, migraine without aura, they're very different.

SB: Right.

EH: Beasts.

SB: Do you also... I don't know how you define an aura without migraine.

EH: You can. They're quite common in the elderly.

SB: Thanks, because I get them.

EH: I'm sorry about that.

SB: And I have for many years.

I don't have any comments from the viewers on that.

EH: They're quite common and you have to differentiate them between TIAs and things obviously when they happen in the elderly. But yeah, you can get auras without... That's in the classification, ICHD.

SB: Right, but we were going back to treating the hypermobile headaches.

EH: Yes.

SB: It's more common in migraines in hypermobile or was that just a connection that women may be more likely to be hypermobile than-

EH: They do seem to be a connection between migraine... but not exclusive. But they are difficult, they tend to be very difficult to treat and nobody really knows... And that's not just from a physical point of view, but that's also from medicinal point of view. It's difficult one that one.

SB: What would you do in terms of... leaving aside your acupuncture, what would you do in terms of advising the patient who's in front of you, who presents with that sort of problem? Now this is not really subject to ASA guidelines because you're not put it on your website, it doesn't come under their auspices. But if someone's sitting in front of you saying, I get a migraine with or without aura and I'm hypermobile, what sort of advice would you be giving them? You think you might be able to help or?

EH: I think you've got to be really frank and honest with your patients and right from the beginning, there is no cure for migraine anywhere. So you've got to be frank with your not looking for a cure. I think the first thing I do with any of my migraine patients, but particularly... well, any of them, whether they're hypermobile or not, is talk about the lifestyle stuff because we know migraine brain, as I said before, likes routine. So if you're not having regular sleep patterns, regular eating patterns, skipping meals, not drinking enough, not doing some moderate exercise, not... then we know that your migraines are... So you can just give them the information.

SB: I think Helen did a presentation on this at the osteopathy convention four, five years ago.

EH: Yeah.

SB: About, I think the connection with diets and... It might not have been Helen, she might've been coordinating it, but it's a connection between diet and migraine and other factors.

EH: Yes. But it's mostly... I mean there were a few supplements and dietary stuff that you can use. So that would be the next in lifestyle, but then the lifestyle, it's not really what you eat, it's more skipping meals. So getting that sugar dip.

SB: Okay. I wanted to bring this thing up as well because this apparently has some evidence from... Insufficient evidence to satisfy NICE regarding the treatment of migraine, doesn't it? And it's called a-

EH: GamaCore.

SB: GamaCore. Okay. What's it doing?

EH: Well, there's a few, they're called neuromodulator devices and there's been quite a lot of interest in the migraine world. There's this one gamaCore, this one is designed to... It's a vagal stimulation, so it feeds in to the parasympathetic reflex.

SB: And these are sold for patients use?

EH: Yes.

SB: So they can go and buy one over the shelf even boots or-

EH: I don't think you can. No. I think you have to be prescribed it by a consultant. I think they've got the thing at the moment. There's also other devices there's a TMS, Trans Magnetic Stimulating device, which is this big device that you put on the back of your head, which has been around for years. They've done quite a lot of research now for migraine with aura and that they think depolarizes the cortical spreading that goes through the aura.

SB: And the evidence is robust enough for NICE?

EH: Yes.

SB: Okay.

EH: It's quite lot of interest in it.

SB: Yeah. Okay. So with that sort of device, would you send someone off to get one of those or would you just say go see your GP and see what they'll say?

EH: No, I don't think you can send them off.

SB: Perhaps I should rephrase that. Would you send them to the GP and say, could you get me one of these? I mean, or would you say-

EH: I don't think the GP can get you one. I think you have to go to a neurologist. As far as, I know that's where you have to go through, as it stands. I don't think... It's good to know about it because some of your patients will come in saying I've tried it, and it worked or it didn't work.

SB: Do you know the percentage of success that they have?

EH: No, I can't I don't know the percentage.

SB: Okay.

EH: But they like it because it's non-pharmaceutical and it's another treatment option and it can be, again, it does well in double-blind RCTs because it's a defined power, it's a quantitative intervention. So that's... And it's easy for them to do, so that's why they-

SB: Unless you had a question about Thunderclap headaches, which I was trying to bring up earlier on. This is from Claire who's got white wine and apparently is very envious of Mark in Menorca and she says, have you heard of Thunderclap headaches? She had a patient with them some years ago, sudden agonizing pain that everyone thought was a stroke. She was investigated for everything and Thunderclap headache worse than cluster headaches, she was told was the diagnosis. Claire hadn't heard of them then and still hasn't since.

EH: Thunderclap is normally reserved for the... Well, it describes the sudden peaking in five minutes to severe pain. I've only ever heard it in the context of subarachnoid hemorrhages.

SB: Okay.

EH: But severe paroxysmal hemicrania is one where you get sudden agonizing pain on one side or clusters is normally, it's not... When you get into it, you realize that it's not so quite neatly compartmentalized, but in fact, when you look in the classification, the number five is always a headache. That's not easily identified by anything else.

SB: Would I be writing thinking that Thunderclap is a very nice descriptive term for a very severe sudden headache, but it doesn't tell you which of the particular categories your headache might fit into. Sounds as though cluster would be-

EH: Yeah. It wouldn't be tension type. It wouldn't be migraine. It's sort of process of elimination.

SB: Yeah. Okay. Right. What have we got now? What are the current thoughts around cluster headaches and micro doses of psilocybin? That's magic mushrooms, isn't it? I had heard that there was some promising initial research sounds like someone is optimistic to me, but-

EH: I think it's quite a lot of research into... I don't know, I can't comment on that. I think there's research into cannabinoids, there's research into a few bits and bobs, but I'm sure all-

SB: We'll try and find something to put up on the website.

EH: All the latest research now OUCH which is a really good place to go. It's patient led but they're very well informed on the latest research so if you want to find that out I suggest you look at OUCH.

SB: When I looked at, OUCH, I think I saw that you have to be a member to get any material from them. Is that the case?

EH: I'm not sure.

SB: I could be wrong.

EH: I'm not a member of OUCH, I'm a member of BASH. I can't help you on that one, so.

SB: Right. Okay. Well, we'll look into that one as well. What else have we got? Someone's asking can extreme yoga positions cause headaches?

EH: I think anybody whose done extreme yoga positions probably would see yes. In theory, cervicogenic headaches if there's a lot of compression, if you're doing headstands and you've got a latent disc issue, then that will create some sort of headaches.

SB: Is there a single projective mechanism for cervicogenic headaches?

EH: No.

SB: While people are just saying, well, there's something going on in the neck and if we fix it, that stops the headache, therefore it was cervicogenic.

EH: Yeah, there's a bit of... I'm not quite sure about cervicogenic tends to suggest it begins in the neck. So the way that the American headache society differentiate is if you can put an injection into the facet of C3 or C6 and the headache goes, then that has confirmed a cervicogenic headache.

SB: Okay.

EH: But then there's a whole little line, I think influenced more or headaches influenced by the cervical spine or exacerbate it or facilitate it. I think there's more of that connection than just... this is my humble opinion than one thing causing the headache. It's like another... Most headaches are threshold and it takes a few things to get to the threshold, and maybe a neck issue is enough to take it over the threshold, but it's not the one and only cause. But that's my humble opinion. That's-

SB: Interesting because that, of course, will allow us to say on a website that we can treat all sorts of headaches if we feel that sensitization process is a contributory factor. And you've said that sensitization is known to be a contributory factor in other non psychogenic headaches.

EH: Yes. It's is sort of a bit of a chicken and egg, what comes first?

SB: Yes. Okay. Well it's something worth bearing in mind… argue with ASA.

EH: It will be, but I think until you can pull out a nice bit of robust evidence where you can... anecdotal is just not enough.

SB: No. And I'm very fond of pointing out to people that unless the ASA specifically says you mustn't say something, you can still say it as long as if they tell you not to, you take it off your site. I mean, you've got to have some reason for saying it. And if you've found some research, which seems promising, maybe worth trying. And I'm not suggesting anybody breaks the law or anything like that, but sometimes there is research and you can put it on your website and defend your position.

EH: Yeah, I mean ultimately, our responsibility is to the patient that walks through the door, and you've got to be honest with them. And if you've got no evidence to suggest... you can't pretend otherwise or if you can... That's who your responsibility is to, so you've got to be safe. You've got to be... And if you don't know if you're going to be effective, you've got to be honest enough to say, I don't know if this is going to be effective.

SB: Yeah. Absolutely. But of course you've got years of clinical experience, and have many of the people watching this program this evening, and that in itself is evidence. It's not sufficient in itself to satisfy a research body that the evidence tells you what you're doing, how you're doing, how effective it's going to be. And you can be honest with patients about that, and I suppose a lot of us do get a bit excited and energized by what the ASA says we can and cannot say. And I'm just trying to find ways where we can perhaps help patients cause we are here to help patients. If there's a patient with a headache and we think we can be of use then we should be letting the patient know that. It's easy to say well unless you know for sure you're going to fix them, you must not say anything. But actually there are cases when we are not quite sure but we might well be useful, don't you think?

EH: Yes. But our use isn't just in the treatment, I think our use is explaining to... understanding, being able to explain. We're in a unique position where we've got time and a little bit of time. So if you've got the... To be able to explain what headache it is and then all those contributory factors, whether... So for example a migraine patient comes in, you've got this whole, it's a threshold disease, you've got contributing factors, you've got hormones, estrogen peaking, you've got skipping meals, you've got not sleeping cause you've got a three month old. You've got a few old head injuries, you've got a stimulus to to screens and you've got to sit in front of your computer all day for work.

You can explain that you don't have to cure everything, but if you can just adjust what you can change... Change what you can change easily and let's see if we can bring you below that threshold. And if one of those things is a very obvious disfunction, physical dysfunction of thoracic in a tight scalings at a tight upper thoracics at a tight... And you can say we can try and change

that, and see if that we can contribute to bringing down threshold rather than cracking C2 or T2 it's going to kill your migraine because that's not...

SB: I do like the idea that we can tell people that contraception is a useful preventative for headaches, that's a good one, then they won't have their screaming three year old. Matthew sent in a question or I think it's an observation actually. He says he wants to contribute that I have treated cervicogenic headaches using HVT as a main modality, almost weekly for around 35 years. And it seems to get a good level of benefit in the short to medium term. Many patients describe these as migraine, but with certain caveats I get reliably good results. Should I stop? Says Matthew, thank Mathew.

EH: That's a decision that I can't make, all I can tell you is probably what I would choose to do. Over manipulate robust and that's whether it's HVT or is vigorous soft tissue or on a hypersensitive neck, you've got a chance of quantifying it. So going from episodic migraines to chronic migraines.

SB: So that's easy. Effectively you are having a very long term effect on what might have been a sporadic problem.

EH: Yeah, so I think we've got to know that, and we've got to be mindful of it. Techniques, I would preference over, were going to be the softer techniques, the quieter techniques into the upper cervicals for sure. Thoracic spine, get those classical techniques, and open up that inlet, and do some nice thoracic mobilizations, and HVTs I think that's fine. But excessive HVT of the C spine, I'm less keen on myself.

SB: But you're not telling Matthew to stop if he's getting reasonable results as he said.

EH: I would say, I'm not telling, I wouldn't tell, I wouldn't tell anybody what to do. It's entirely their decision, what they would do. But I would say work out how often are you doing it, if you're doing that once a week then I would say that's... if you're doing it once a year... But look, come on, let's do some research, some decent research. Let's try and find the proper evidence rather than just my anecdotal or my experience or my preference.

SB: I will give you time to talk to us about research in a moment. I've got a really long, quick... Danieli. Thank you Danielle. Danielle is very fond of two things, long questions and usually long words that I can't pronounce, but he says, Danielle says, over the years I have been treating a friend's daughter for musculoskeletal thoracic issues. Recently she attended for an ongoing headache problem. After a couple of visits, after each week she seemed to temporarily improve the old bells of experience started ringing in his head and he felt it was better referring her back to the GP.

Incidentally, she had before seeing Danielle, been to the GP. She was sent for neurological investigation and she turned out to have a colloid cyst on her cortex as it was creating a hydrophilic environment. She was operated on pretty quickly. She's doing okay now, but getting monitored regularly as I missed this condition, can you suggest any neurological examination that would have helped him to pick up on it? Thank you, Daniela. That's putting you on the spot.

EH: Yeah. No, we have, we've got a great little OPHM put together a great clinical package together to help try and help with that diagnostic confidence.

SB: So this has come from?

EH: Well, us as the OPHM. That's what a lot of what our courses are about and hopefully we'll tell you later about the e-learning course. There is a three minute neurological examination by a guy called Giles Elrington, he's a neurologist with a great sense of humor and a great bow tie. It's a brilliant... It's on YouTube, you can find it, and it's designed particularly for headaches and you can do it in three minutes. So it's very, very easy to do in practice as a screen. But that's just a screen, it's not... it's not diagnostics, it's not our job to diagnose, I don't think in that respect, but it's to have tools that we can... If we're worried we can pick things up.

But if people have got hydrocephalus, the signs of raised intercranial pressure is an orthostatic headache, so that's one of the red flags. If somebody is standing up and the pain gets worse when they lay down or nighttime, that's a red flag when they stand up. If it's low interplay because they've got a CSF leak, it'll be the reverse. So not changing position because I had a patient that came in and it was worse lying down, and my red flag, but then we worked out, it's because her head went into hyperextension.

SB: So the issue is standing to lying down.

EH: It's literally pressure not head position.

SB: Right. One from Trevor McArthur who says you bring in an osteopath who treats headaches or migraines-

EH: I think I know Trevor McArthur.

SB: Oh, you do?

EH: Do I know Trevor McArthur?

SB: I don't know. Trevor, do you know Elizabeth?

EH: A name from the past?

SB: You being an osteopath who treats headaches and migraines, he's assuming you've used cranial technique, which to his understanding, works on reducing dural tension. What's your thinking about a patient who is fine during the week at work, but as soon as they relax at the weekend they get a migraine routinely?

EH: Well that's quite a common pattern when the stress is taken off.

SB: Annoying for everyone.

EH: I know, they haven't worked out why. Science hasn't worked out why, they've looked at maybe... because again is that change, you're going from a heavy working environment to relaxing, and it's that change that migraine brain doesn't adapt to. If you're sleeping in or if you're not. So they haven't found an answer to that one exactly why, but that's what they think it might be. So it's difficult, you can't... Unless he carries on working seven days a week, but it's to try and keep as regular as possible.

As far as treatment is concerned, I do like cranial techniques. I'm not quite sure whether what we think we're doing is what we're doing. And there's some great exciting discovery of the glymphatic system by a Harvard neurologists five years ago, and that's really exciting for me.

SB: Because?

EH: Because when I first heard about it, I thought, oh God, that makes sense. It was one of those little moments, but there's very little literature about it at the moment, so watch the space, and we'll see where that goes.

SB: Yeah. I've often thought that very possibly with cranial, one of it's one of its difficulties is people trying to explain to the conventional fraternity, this is what we're doing. When actually a lot of it is almost impossible to prove what you're doing, and again, it comes back to, well, let's forget what you think you're doing and let's just see what the outcomes are. It's nice that perhaps we're going to get something which might lead us down a more-

EH: Yeah, it's my next project.

SB: Right. Okay.

EH: Yes, I'd like to explore that.

SB: Okay. Somebody unnamed says, as a cluster sufferer, I found the cranial treatments very helpful in improving pain and helping me get out of a bout. I found that manipulation is not helpful and can make things much worse. There's little observation that reflects what you were saying earlier on. And another observation or another question here.

Again, anonymous, interesting discussion. After 33 years of experience of clinical chiropractic practice, I can honestly say that when migraine cluster headache patients present at the clinic, we carefully examined the spine. I assume this means, and if we find a baron biomechanics, we discussed with the patient the rationale for correcting the spinal mechanics. We never claim to treat their migraines, but from clinical experience there's a significant percentage of migraine cluster headache sufferers who do get tremendous benefit from correcting their spinal mechanics.

I'm presuming that means manipulation, but correcting their spinal mechanics could be achieved presumably through the more gentle methods that you mentioned as well.

EH: Yeah. Not just addressing, I think that the... Or not just addressing the upper cervical spine. I mean there's no doubt C1, C2, C3 we know is an important part of the cervical afference, feed into the headache and the migraine pathways. We know that, but it's how you're going to deal with it and how you're going to try and influence that. But spinal mechanics, yeah, I mean if you thinking about open... Again, it's all theoretical really with us at the moment, but it makes sense.

I do it, I still believe it that we've got a massive contribution that thoracic spine, all those sympathetics, those scallions, that first ribs, the... I'm a great advocate for it, but it would be lovely, I would just like us to have more concrete science behind what we do.

SB: Have you looked into the stuff that Leon Chito used to promote about-

EH: I have, but not enough. I feel.

SB: We've got, I think it's two, possibly three broadcast recordings now that we did with Leon Chito, which are all about treating scalings, upper thoracics and all about gas fixtures and how they affect pain perception and so on. Very useful stuff, and he's got lots of science behind it as you would expect, given what he was doing when he was at the journal of bodywork and movement therapy. So worth looking at if you want to follow up on that particular aspect.

Trevor says hi, I've been told to say.

EH: Hello Trevor.

SB: And I know you didn't say that you were particularly concerned about the ASA yourself. I don't mean that in a, you know, you're disregarding them. But someone said, "Could we confirm what the ASA rules," and what osteos can say, they can treat these because whoever this is says they thought we were safe to say we could treat cervicogenic and tension type headaches and a

Google search finds lots of references to osteos helping with tension headaches.

SB: I can tell you categorically that both chiropractors and osteopaths are only allowed to say they can treat headaches of cervical origin, of neck origin. That is clearly set out on the osteopathic and chiropractic sections of the ASA's website and we also, somewhere on our website, we made those guidelines available to people. We will make them available again, it gives a list of exactly what we're allowed to say and annoying though it is, we're not allowed to say we can treat tension type headaches at the moment, but we'll move on to doing something about research in a second. In fact perhaps let's talk about research now, shall we? Because I know you've got... there's a project coming up, an eLearning process coming up, where would you like us to start?

EH: Okay, well we've got a project coming up. It's called EdACHE, great little name.

SB: We've got a little graphic of this, haven't we.

EH: Says what it does on the can. And this is being delivered by OPHM-

SB: Wat was the chance of you coming up with an acronym like that for-

EH: Great, isn't it? I'm in the wrong profession.

SB: Education and assessment for competence headaches. Yep, okay.

EH: So, it's delivered by the OPHM team. It's funded by the Osteopathic Foundation. And it's a three phase project.

SB: Right. So, it's only for us osteopaths?

EH: Well, at the moment it's for UK osteopaths, because phase one is a research paper. So we had to define a cohort. So we defined it as UK registered osteopath. Before I tell you what it is, I'm going to tell you why we think it's important to do. One, because headaches are highly prevalent. 90% of us will get a headache sometime. A massive socioeconomic burden, it's high on the public health agenda, at the moment it's number three on the World Health Organization of Burden of Disease. So number one is lower back pain. Number two, anxiety and depression. Number three is headaches. So you're going to have lots of patients come into your practice, whether they come in with that or not, there will be headaches.

SB: Based on your statistics, I worked out that it was costing the NHS £955 million a year to treat headaches both in GP surgeries and elsewhere.

EH: Yeah. There's a lot of money, and that's why it's high on the public health agenda at the moment. They're trying to find solutions, so it's quite an exciting field to be in. Money wise, I think 500, just under £500 a year per patient is what the NHS spends and that's just the average. There were 5,000, around 5,000 of us by last count, and it was the old NCOR. They'd just done a new one. And out of that, that's 30,000 consultations a day. Seven percent of them.

SB: Sorry, there's 5,000 of whom?

EH: 5,000 osteopaths at the moment, according to NCOR, just over 5,300, and 30,000 consultations everyday. Seven percent of those are for head and facial symptoms. So by my reckoning, that's 2,200 treatments every day that we give for headaches.

SB: Which would be a great cohort for research projects, wouldn't it?

EH: And so we're doing it but we have to look at ourselves. At the moment, there's very little robust evidence. And as I said before, Sarah Telles systemic reviews, systematic review show that... one of the reasons was people weren't able to differentiate between headache types.

So, a big mission for the OPHM is, well, the mission is education, collaboration and research. That's where we want to go with... because we all passionately believe we've got a contribution to make. We just want to do it better. So that said, the why we're doing it, that-

SB: I'm busily putting your slides up, I'm hoping that these might be relevant because-

EH: Yeah, they're great. So, this is why we're doing it. This project is all about improving your diagnostic confidence in the clinic room. So for the practicing osteopath clinical, what you do on a Monday morning when the patient walks in, what do you look for, what signs do you do? And that will inform best practice. So again, that will be good for our patients, and if we have a cohort of UK osteopaths that have been shown to be able to, then we can start doing some data collection, and some proper research. That's why it's quite important to do, and that's why we're quite excited about it.

SB: This bit here, this diagnostic confidence in the treatment room... I mean, I'm getting the sense not just that people are not terribly confident, but also there's a body of practitioners out there who are confident, but maybe without good reason.

EH: Ill-advised confidence.

SB: Yeah. Because we get taught certain things in clinic and in college and so on. And so clearly, you're agreeing. So, these are situation... So, where are we going from here then?

EH: So what's next?

SB: Ready to move on?

EH: What's the next phase? So there is, it's a three phase project. Phase one, which we're just about to launch in October. What we need to do first of all, is see what we know now. We're looking at what's the knowledge of headaches... as amongst the level is at the moment, as we stand. So we're doing this anonymous survey, so it's not assessing the individual. It's going to be anonymous, we just want to see where we're at, and the findings of that will then inform the creation of an eLearning course. So we can put everything tailor-made, particularly to the needs of osteopaths. Everything that you need to know about headaches, eLearning so it's accessible to everybody that wants to...

SB: And again, you said for osteopaths, but the eLearning would be available to everybody ,right?

EH: Yeah. While the project's going on, while we're doing it, it's going to be limited to... Because we could then go into test that eLearning course to see if it actually does what it says on the can. And once, so then we end up with an eLearning course, and people that have done this eLearning course is approve... It's credible that they have a certain level of knowledge. And that is only good for patients. It's only good for the practitioner, because they can demonstrate that they've got a certain level of knowledge. And as I said, beyond that, then we've got a list of UK osteopaths that have a defined, standardized level of knowledge of headaches. And then, beyond the project, then we can start doing standardized data collection and proper research. But until we have that baseline of knowledge, I think we can talk anecdotal forever, but we're never going to get anywhere.

SB: So this is actually very helpful for all professions. Do you know if anything similar is going on in the chiropractic world as well?

EH: As far as we know? No. There's, a few courses that, you know, as far as we know, not... as far as we know we're the first allied health professional to take a look at ourselves and say, "What's our current level of knowledge?"

SB: Yeah. Okay. If you know different, and there are chiropractic research projects ongoing, then do let us know because we need to share this information with as many as people as possible. And as you've said, once this has been proven to work then it's going to be open, hopefully to all practitioners.

EH: Yeah, once this model... the eLearning course, once we've gone through and made some robust... Made sure it's accurate, it's up to date. We've got some great collaborators. But at the moment, it's for UK registered osteopaths, for no other reason, but that's because we need that defined cohort.

But we will then, it will be accessible for any allied health professional that wants to... Acupuncturists, physiotherapists, chiropractors. That's where we will go.

SB: Okay, so I hit the button earlier-

EH: So that's who, and what's next? What's the next one? So yes, we're promoting it in September. This is, as we're doing now. And then we're going to... What we need is participants. Any decent research needs numbers. The more numbers we have, the more robust the research. So it's, the survey is a 10 minute questionnaire. As I say, I reiterate, it's anonymous, so this is not a test of the individual, we're not... It's just, we just want to get an idea to inform the next phase. So 10 to 15 minutes and it-

SB: And we can't do that until 21st of October, is that-

EH: No, it's going to go live, and it will be live for four weeks.

SB: When you do go live, if you remind me, I know you'll publicize this through the GOSC, through the IEO, through every other... We'll do it as well just to try and get it out as much as we possibly can.

EH: Yes, please. Any of your viewers, if you can encourage everybody to do it, however long they've been in... We want a broad spectrum, experience, inexperience. It's not students at the moment, it's just the qualified... A rural multi-practice sole practitioner. We want a really broad spectrum, for a good study. And then we're really pleased. The collaboration is brilliant. BASH who are the UK leading neurologists in headaches-

SB: British Association for the Study of Headaches.

EH: Yeah, they're collaborating with us on phase one, and to make sure that the questionnaire is relevant and accurate... and the survey. The phase one is going to be my master's thesis for my University of Copenhagen. So ,I'm going to be defending this in front of a panel of Massoud Ashini who is the president of the International Headache Society, and Wilmore Jensen, big neuro names.

So, it's going to be really a great opportunity to show that osteopaths are taking this headache business seriously. As I said, Osteopathic foundation have funded it for us, which is great. The UKO are helping us with the research and with the eLearning course. So, all we need is the profession to get on board with it now.

SB: What's the IO's rule at the bottom there?

EH: They are... Well, they're in collaboration with the OF, with Osteopathic Foundation, but they really supporting us, because they think... they can see it. So, it's a benefit to everybody. Whether you don't even want to treat headaches, if you're a sports osteopath. And it just gives you that to find, okay...

SB: You do need to know about... you need to know about the mechanisms.

EH: Yeah. You should tailor-make it to whatever level. So, these sort of things are going to be... You're seeing them out. These are the sort of things that are going to be coming out. Just to remind you, and this is-

SB: You'd like everyone to see this, wouldn't you?

EH: Yes, please.

SB: So what we'll do is, we'll show this video now, but we'll also put it up on the website so that people can share it. It's a funky little cartoon thing about the project, isn't it? So, Justin, roll the video.

Video: What goes through your mind when a patient presents with a headache? Safety, warning signs... Am I confident in my diagnosis? Should I refer? OPHM wants to help. So we're launching our EDACHE project. EDACHE stands for Education and Assessment for Competence in Headaches. It's an Osteopathic Foundation funded project. We need your help, firstly to see where we are now. Secondly, to tailor an eLearning course for osteopaths. Finally, to demonstrate an agreed standard of competance. Here's how you can help us to help you, and give you free CPD in the process. From October 21st, we will send emails to all osteopaths on the GOSC register, who have agreed to be contacted for research. Look for our mail in your inbox. EDACHE, developing high standards of competence in headache management.

SB: We're back in the room. We're back in the studio. A useful little video which we'll publicize to everybody. You forgot to say the course is free. The eLearning course, once it starts.

EH: For all the participants of the phase one survey, they will be offered the eLearning course.

SB: So, you're going to know who they are, even though it's anonymous?

EH: Yes. Well, we've got to take... There's going to be a link before you get into the survey, where you tick a box and we'll be able to collect your... Catch your email address. So, this is going to be sent out. Then the last one is going to be when it's actually live and then you just click on here and it will take

you through. So we're going to try and make it as easy as possible for you to do it.

SB: Okay. There's been a whole load of questions that have come in while we were talking about it, while we were showing that... that thing there, which hopefully we will cultivate, encourage some more support for it.

EH: Please do.

SB: But I like this one, I like to look at this one. It says... It's Matthew Davis, who says, "A couple of years back I had a frank exchange of views with a PhD physiotherapist involved in functional MRI. He claimed that neck manipulation, HVT, always caused a degree of brainstem ischemia and forcefully claimed that they should never be done." I'm not sure... I'm not sure if that's quite along the lines of what we're discussing here, in terms of headaches, isn't it? It sounds like an argument against HVT, against manipulation, rather then-

EH: I mean, the fact is that if you want to get anybody on board as far as treating headaches, you have to understand that most neurologists will have seen people come in with arterial dissection. So if you're speaking to them, that's the first thing they think of. You're never going to persuade them the HVT is a good idea. In my opinion.

SB: No. So-

EH: Whether that is a reason or not to do it, but if there's other ways of...

SB: Some interesting stuff coming in here, I'm as always beginning to rush a little bit towards the end to try to cover all the questions. I don't know who said this, but they say that they recently spoke to someone who's using cold water immersion for migraine management. Is there much evidence for it?

EH: There is, quite a lot!

SB: Could it be improving habituation to changes in environment?

EH: No, I think there is quite a lot, this new phase of open water swimming. There's quite a lot of evidence that it helps, whether it works on a vascular level or not, we're not quite sure. But there is.

SB: Basically complete immersion in cold water.

EH: Yes. And most will know that because they'll go for the cold pack.

SB: That's presumably not going to be as effective. You need a greater degree of cold to achieve a better result.

EH: No, but people use it. It's a little easier to get hold of when you've got a migraine.

SB: Indeed. What else we got? Do you think we should contribute more to NCOR, or to somewhere else to help get more research for our two professions?

EH: Absolutely.

SB: Which?

EH: I think NCOR is doing a great job. They are helping us a little bit with this. Yeah. I mean, if every osteopath could just put a 50 pence on their treatment and tell patients 50 pence of every patient treatment that we give is going to go to NCOR, because we believe in research... Every other company's doing it for ethical reasons, you know, it's a good marketing. I think it would be a brilliant idea, because there is no money. We haven't got, got the pharmaceuticals giving us money. So yes.

SB: And just in case anybody is any doubt, NCOR is the National Council for Osteopathic Research. So again, limited to osteopaths I imagine, but there must be a chiropractic equivalent with which I'm less familiar. I would like to think there is anyway. Jason's asked the interesting question. Do you remember, I don't know, 15, 20 years ago, everything was supposedly related to a head forward posture and upper cross pattern, head forward posture, connection with headaches of any sort?

EH: Neck retraction. That's one of the techniques that Dean Watson uses and the physios use.

SB: I didn't ask you about this, this is something I saw on your website. The Watson Technique.

EH: Dean Watson is a Australian physiotherapist. Some people heavily agree with him. And some people don't.

SB: So again, lack of research to prove it either way.

EH: But he has done research. He's a guy that will, he and Drummond, Drummond and Watson. Drummond's done the research, they've used this clever blink reflex to show some evidence of what this... He's good. He's trying his best to to deal with this.

I'm sorry, I lost my track. What was I thinking of?

SB: I was asking about the head forward posture and headaches, is there evidence to support.

EH: The basis of his treatment is reproducing the headache and then resolution. So he will, part of his will be putting pressure, inhibitory pressure, over C2 or three, or the facet, or various bits.

I won't go into details, I've done two levels with him, it's quite interesting... And if you can reproduce the headache with pressure, and then it will resolve with sustained pressure, then that's a good sign him. That's the basis of how he works on it. But it's quite a clever... They use the neck retraction for that too. So if you, one of the first tests I will do for a patient is ask them to retract the neck and if that reproduces their headache or even takes the headache away, you've got that automatic then, you know there's an influence between... you've got that automatic connection. Okay, there is a link.

SB: But by definition from what you said, it's not necessarily a forward head posture that's causing headaches?

EH: No, but I think there's a, there's quite a lot of, in the physio world, this cervical dystonia and anterior cervical flexors, they've done a lot of work on that and there has been proven that there's a lack of strength and tonicity in the cervical flexors with headache sufferers. So it is part and parcel, but then I think we can see, you know, if you've got thoracic inlet, that's in a thoracic spine that's taking whatever you... You can translate it into osteopathy, I think.

SB: Okay. "What's the best way," asks Tom, "for manual therapists to promote longterm desensitization of the upper cervicals if insufficient evidence supports HVT."

EH: Oh, I don't know if I can give you an absolute answer to that, but I can tell you in my experience, it would be more inhibitory. More pressure, no stretching, not stretching.

SB: Trigger point work?

EH: Yeah. I think trigger point, it can help. I don't use it a huge amount.

SB: And you fall back on kneeling quite a lot?

EH: For? No, not always, but I do use it. No, my techniques, my favorite technique is classical, and cranial, and inhibitory, and functional. So quite quiet, quiet ones.

SB: Is occipital neuralgia an outdated concept? And if not, what are the treatment options for sufferers?

EH: Ah, occipital neuralgia. Yes. Though there's... lots of people argue about that little label. It’s occipital nerve, greater occipital nerve. We know that that's what the greater occipital nerve blocks do. Is it an outer term? It's not one

that's often used now, but it's still valid. It still says what it does, nerve pain, occipital nerve pain.

SB: Yeah. Okay.

EH: What was the second part of the question?

SB: What are the treatment options for sufferers?

EH: The traditional, the mainstream one would be medication first and then Botox or great occipital nerve injections. That's the path that they would probably go.

SB: Well tell us about Botox. Have you used... Do you, is there someone in your clinic who uses Botox? What's its role? Where does it work?

EH: Again, everybody's out of... It's quite interesting being in Denmark because in Copenhagen, because you get all the neurologists discussing amongst themselves and you realize that they've got as much disagreement amongst themselves as we have sometimes. The Botox pharmaceutical company, Alagam, I think it is. I'm sure other people do it. They spent quite a lot of money trying to prove it, that it worked. And eventually they had a couple of studies, about 10 years and a lot of money. And then they've got a couple of studies that proved that it did.

So it's evidence based, but when you speak to nurses, headache nurses that inject and it's just... "Well, we're not quite sure. Sometimes it works, sometimes it doesn't." That generally is the answer you get with headaches, across the board. "Sometimes it works and sometimes it doesn't." Even with the new wonder drug, the CGRPs that have come out. So they are complex.

SB: A quick reminder, who was it does the three minute video that's on YouTube? We'll post it on the website afterwards, but someone's asked for a quick reminder.

EH: Giles Elrington.

SB: Giles Elrington. So, three minute video on screening headaches.

EH: Very useful. They use it in A&E and it's great. Very good. It's very good.

SB: Yeah. And as a final question for you, have you got good at doing ophthalmology since you started treating headaches? Or is that overkill?

EH: No. No I wouldn't... Well, I know what to look for theoretically, but I wouldn't say that I have the expertise. Because you can get pseudo papilledema, papilledema. And so if you really want to do the job properly, I'd leave it to the experts. So no, I would leave that one to the experts. Fundoscopy is one

of the things that you have to do at the very beginning for a new onset headache, new onset headaches.

SB: Okay, you have to do quite a lot to be good at I think, which is, you know, tends not to be our-

EH: Yeah, and often the GPs are not confident as well, in doing it. So then the GPs on the headache core, say well, "Give it a go." So, if you've got an ophthalmologist… do use that. Or just ask the GP to do it. But yeah…

SB: So in terms of current training options for people, what should people be doing to improve their knowledge of what they can do for headaches?

EH: I think you need to start off not what you can do for headaches, but you need to know about headaches. I think that's your responsibility as a practitioner. So you need to know... yeah. And then be on that-

SB: So where's the training option for that? What would you suggest that they do? But that's not available yet-

EH: But it will be.

SB: How soon do you think the course will be available?

EH: Well this phase one is going to be next month. As soon as we've got the results of that, then the eLearning course can be developed. So I would say in the next year.

SB: Right. So within a year, we'll have an eLearning course to get people started.

EH: That's the aim.

SB: Brilliant. Elizabeth, thank you. That's, obviously it's not encouraging that there's so little evidence, but it's great to have someone to come in and tell us what there is and where we can go to make it better. And hopefully the chiropractors have got a route by which they can feed their own information into a similar research project, but at least at this stage, osteopaths have got somewhere that they can put their things and it's a 15 minute questionnaire. Anonymous.

EH: 10, 15 minutes. Really clinical applicable stuff. Stuff that you'd come, you know, so it's not highfalutin research. It's stuff that you would be, in the clinic...

SB: And if you've done that, if you've taken part in that survey, then you'll have free access to the learning course afterwards,

EH: You get the free CPD course.

SB: Wonderful.

EH: Yes. After the project's over, then that will be at a cost, but all the money will be going back into research coffers.

SB: Brilliant. Thank you very much.

EH: You're very welcome.