Episode 2: The Road to Diagnosis & Care | Taking Charge of Headache™

Melissa Farmer-Hill
Hello and good morning everyone. I am Melissa Farmer-Hill and I really just want to say that I'm so glad that you are attending Taking Charge of Headache™ this webinar series, and it was created especially for women veterans and their loved ones. And I think that's really special. We know that, for many people, and it's probably why you're here, regular headache attacks can be a significant burden.

We also know that navigating through the health system can be frustrating, especially when it feels like you've done all you can. You've done everything right, but you still don't have any relief. And that's exactly why we created this series. We want to try to make it easier to get you the help you need and deserve. This webinar series, of course, is a partnership between the SHERO Coffee Club and Operation Brainstorm™.

Now at SHERO Coffee club, we don't just sell great coffee. But we are also about empowering women veterans through connection and advocacy. And that's one of the main reasons why we are here. Operation Brainstorm is a program from the National Headache Foundation dedicated to supporting military community members living with headache and migraine.

And I'm going to go ahead and let Diego tell you a little bit more about that.

Diego Colón
So, in the first session that we did last month, we talked about why veterans experience headache and migraine attacks. We covered different types of headache disorders, how symptoms can vary, and some first steps to consider. If you missed that episode. No worries, we'll drop it in the link. We'll drop it down there in the chat. You can watch it.

Watch Episode 1 Why Do I Get Migraine and Headache Attacks? | Taking Charge of Headache™

Please run up those numbers. Catch up on the previous episodes. Today is about what happens next for an effective treatment plan. It starts with a diagnostic process. So, during this session, what we will actually be speaking about is questions your provider may ask, exams and tests, warning signs that require extra attention, and when imaging might be recommended.

Afterwards we'll do breakout rooms where you can reflect on what you learn, ask questions, and share your own story, if you're comfortable. Okay, great. One more time. Shout out to Melissa Farmer-Hill, retired Army veteran, entrepreneur and author earning over 20 military awards including the Legion of Merit and Bronze Star with deployments in Iraq and Kosovo. Founder of SHERO Coffee Club, a dynamic platform that empowers women veterans through community storytelling and advocacy.

She holds a master's degree from, same alma mater, I don't know if we've talked about that Melissa, Roosevelt University and is a lifelong member of several veteran's service organizations. The mission is clear, to ensure voices and stories of women who served and honored are heard.

Melissa Farmer-Hill
First, I want to say thank you for allowing me to share my story. You know, SHERO coffee club, we're always talking about our journey through not only our military experience but our life as well. And I think stories are powerful because they can help someone else. So, I'm just going to share a little bit of my headache and migraine journey.

I retired from the military. I did 20 years active duty in the military. Now throughout pretty much that entire time I had allergies, not seasonal, year-round allergies, year-round sinus issues. And so, I would take Benadryl and Aleve. And of course, they would give you the, I think it was, 800 milligram ibuprofen. And that's what I was taking.

But what I didn't realize was that these headaches that I was having, it wasn't the sinus, it wasn't the allergies, it wasn't that at all. And granted, I spent a military career, you know, at least the greater part of ten years mixing, doing that little mix of cocktails, thinking it was sinus and allergies. And it wasn't until about three years ago that I started getting these headaches.

And one thing I remember about these headaches was the boom boom. I just remember that sound. And, the only thing I could do with these headaches was lay down, close my eyes to try to find some, I guess, solace, some rest, to make it go away. But it wasn't until I actually went to the doctor, because one of the things that I was afraid of, my nephew at the age of nine, died from glioblastoma, which is brain cancer, and that and one of the first things that I remember he experienced was the headaches.

So of course, when I started getting that booming headache, it was like, oh my goodness. You know, our family, we've become really aware of headaches now. I went to Jesse Brown Hospital and Doctor Patel worked with me. We did the scan, and we found it wasn't cancer or anything like that. We did a couple of tests in her office.

We tried one medication, and we tried the medication that I'm currently taking now, and it's been working for me. The migraines are less and less. And so, my whole story is to say to you, don't self-diagnose, don't self-medicate. Because I think about, you know, every time you take medicine, it does something to your body. And all of these years where I was doing that little cocktail thinking, oh, yeah, this will help.

Until it didn't, I didn't have to do that. And if I had just gone to seek the help when it first started, I would have been okay. But make sure you get the right medical attention you need. So, you're not out here googling on Doctor Google and self-diagnosing and self-medicate. And

that's really my story and I hope it does help someone out there who's thinking about, should I go to the doctor or shouldn't I go to the doctor. Also if you have a headache story, they're always looking for stories about your experience, because the more we share, the more people know.

And I just want to I just want to end with that. Again, thank you for letting me share a little bit about my experience.

Diego Colón
Speaking on the power of stories. If you're interested in sharing your story, let us know in the chat. We would love to know that you are not alone. We are actively working to uplift veteran experiences so we can encourage fellow veterans to seek health, raise awareness about the challenges veterans face, empower others to share their experiences, and as a thank you, if we publish your story, we'll send you a really cute migraine relief kit to support your journey.

Now let's talk about what happens during a headache evaluation to help us navigate this. We're honored to have Doctor Karen Williams, DNP, FNP, who brings over 40 years of experience in the health care field with extensive expertise in using an integrative approach to headache and pain management, as well as treating servicemembers and veterans at the Traumatic Brain Injury Program in Landstuhl Regional Medical Center in Germany from 2008 to 2013.

She retired in 2023 as Deputy Director of the Central Virginia VA Headache Center of Excellence. Having led veteran focused programs in Texas and Germany. A recognized expert in integrative medicine and acupuncture, she co-chaired the National Headache Center of Excellence Education Committee and contributed to 2023 VA DoD Headache Guidelines. So, 20 years of public speaking experience.

Also, she continues to mentor healthcare professionals, including me, in headache and pain management and helping teach just like me. Doctor Williams, we're so excited to have you here. Let's dive into what happens during a headache evaluation and why it's an essential step in your healthcare journey. If you have questions, drop them in the chat.

Dr. Karen Williams DNP, FNP-BC
Thank you, Diego. Well, it's a pleasure being here. Thank you so much for all who have joined us. I want to start by just kind of reviewing just a little bit and just kind of talk about an overview. So, what are headache disorders, there are many different types of headache. In fact, there's about 150 of them. So, you may have more than one type of headache.

We're going to concentrate more on primary headache today and primary headaches there can be a genetic component to it. It can run in families as well. So, you're more likely to have that. Now, in the next slide, I will talk about the difference between a primary headache and

some others. Now, in the last 25 years that I have worked in neurology and headache medicine, we have really come out with numerous other options as far as treating.

And even though we still don't have a cure, we may never have a cure, but we have better abilities to be able to treat both the attack at the time and then also to help prevent further ones. And so even though we don't have that cure, there are numerous options. And just remember, you are not alone. There are millions of folks in the US that have headaches.

And so, we're here to help support and, give you some guidance on that. So, as I was talking about the common types of headache, primary headache are headaches that do not have any cause, so there is a genetic component to that. But they're are also just that, it's part of your body, your body makeup. The most common is tension type headache.

And as you can see by this, there is episodic and chronic meaning there's some that come and go versus others that extend for a much longer period of time, or you're having multiple of that during that month. Migraines are not as common, but they are much more debilitating. And that's the one we are going to focus on today for the most part.

Again, episodic [migraine]. So you'd have less than 15 days per month of headache and then chronic [migraine] hitting more than 15 days per month or having 15 days a month. Which is a really long period of time to be having the migraines. And then there are cluster headaches. We're not going to get into those today, but that is another type of primary headache that also can run in families.

That's usually more male than female versus migraine, which is more female. And some of that is related to the menstrual cycle of women. Secondary headaches occur because of some other cause. So, one example is post-traumatic headache, which is related to some sort of trauma. Another one, that I will just kind of talk about, just a touch is medication overuse headache, which Melissa may have had because of all of that self-treatment she was doing.

And I loved her advice. Don't self-treat, don't try to self-diagnose. It is important to be able to start looking at it and saying, hey, you know, I've been taking a lot of this medicine, but if you take too much of it, so if you're taking more than two days per week of that medicine for an extended period of time, you may increase not only the number of headaches that you have, but may not be effectively treating the primary headache that you had.

I'm just going to talk for a minute about post-traumatic headache. Post-traumatic headache is one of those things that I saw quite often, not only while working in the head injury program at Landstuhl Regional Medical Center, but also when I transitioned to the VA. There were many veterans that I saw that had components of that. And while we don't have an exact treatment for post-traumatic headache, what we have guidelines wise, what they have decided is that you treat it according to what it looks like.

What are those characteristics? Most often it resembles migraine or tension-type headache or both. Now there is a portion that also have what we would call occipital neuralgia. I saw this, very often in my veterans, and often it was under treated or, and then cervicogenic is something that has to do with the neck. So often we see that in like a whiplash or any type of head trauma.

Dr. Karen Williams DNP, FNP-BC
But if you were to touch the back of your skull about a thumb width over from your midline, there's a little indentation. And that's where one of the occipital nerves lie. And if that gives you pain to the back of your head or radiates to the front behind your eye, there may be a component of the headache that needs to be treated.

If you slide over about another thumb width, there's another little notch there. And that's another occipital nerve that is our lesser occipital nerve. And that also, can be irritated. So obviously a combination of all the above you could have and breaking that down and figuring out how to treat each component is really important. I'm going to talk a little bit more about migraine per se.

Just to kind of give you an overview. Unfortunately, there are no imaging or lab work or anything like that that can say, yes, this [migraine] is what you have. It can rule out what you don't have, but it does not necessarily tell you that's what you have. We diagnose migraine according to the characteristics. And so as you see on the screen here, you have to have at least two of the following.

One sided pain, now that in some folks is both sides but it can be one sided. The other part of that is similar to what Melissa was talking about. That throbbing, pounding, pulsating type or pain is very common.

The intensity is usually moderate to severe, and it slows you down.

So, you can see aggravated by physical activity. Like Melissa, she wanted to lay down in a dark place and makes it very hard to be able to do your physical activities that you're supposed to do for that, the time period that you're having that [migraine].

In addition to those characteristics, what you should also have is at least nausea and or vomiting or light and sound sensitivity.

Now, I will tell you, most of my patients with migraine had almost all of the above. But those are the absolute characteristics that will be able to help us diagnose or define that migraine is one of them. And I alluded to it before, episodic migraine is less than 15 headache days per month for greater than three months, and then chronic migraine is 15 or more headache days per month.

The significance of chronic [migraine], even though it's much less [people]. There are many folks with chronic [migraine], it's much more debilitating, much less likely to be working full time. Not only are you less likely to be at school or work, but also when you are there. It's called presenteeism. You're not able to fully engage in what you're doing, and so we want to be able to stop going from episodic to chronic migraine, but also then possibly reverse going from chronic back to episodic [migraine]. And so that's the importance of getting the correct diagnosis

And then the appropriate treatment. We had brought this up last time at the last webinar, it's ID migraine. This is a self-screener that was developed in 2003. And it has just three questions on it. And the nice thing about this is it does not rule out other types of headaches, but it gives a good idea to you, and perhaps to the provider that migraine may be one of the types of headaches or the type of headache that you have.

Dr. Karen Williams DNP, FNP-BC
And so if you look at these questions, does light bother you when you have a headache? Do you have limited activity and are you nauseated or sick to your stomach? Now another way to look at these, light bothering you is **P**hotophobia. Limited activity, consider that **I**mpairment and then **N**ausea. So, **PIN**. If you answer yes to 2 or 3 of these then there's a high probability that migraine is one of the types of headaches you have or is a type of headache you have. And it doesn't necessarily screen out other ones, but it gives a good idea for that.

So, there are red flags, and there are reasons that you need to see the primary care provider sooner rather than later. Even if you've been diagnosed with migraine. So, if you are a person who's having persistent daily headache or a headache that never goes away, if you are older than 50 and you have a new headache, that's extremely important to get into your provider because there may be something else going on.

If you are somebody who has a weakened immune system and you're having new headache attacks, that's another reason. Or if your headache is also accompanied by fever, chills and sweating at night. And if your headache happens when you exert yourself so you're bearing down, you're coughing or sneezing, or you're changing your position. That is another reason, especially if these are new, if the headaches are now waking you up at night and if you're developing a headache after a head injury, and I will tell you, headache is the most common symptom after a head injury, along with, some of the other issues that we commonly see in a mild head injury is also, considered called a concussion.

So, if your headache is also accompanied by fever, rash, weight loss, neck stiffness, confusion, speaking problems, vision problems, weakness or dizziness. Yet another reason. And then if the headache is different from your usual headaches or it's just not resolving with your treatments.

Now there is one that is extremely important to know and needs some urgent care and that's if you get that sudden headache that basically takes you down to your knees or you fall down.

It's called a thunderclap headache for a reason. And that is an indication of a bleed in the brain. Those are emergent and that needs to go straight to the ear. I can tell you, in my 25 years in neurology, I never had a patient come into my office saying, hey, I had this really severe headache last week that I felt like somebody whacked me upside the head. Usually, they go to the ER. That would need immediate imaging as well.

So, one of the important things you can do before you even see the provider is track the headache [days]. It can be a little bit complicated. And some patients feel like "I'm doing a lot of work", but doing a three-month headache diary is really important in order to figure out; how long are the headaches lasting, how many different types of headaches you're having, and then also marking what days are headache free.

Dr. Karen Williams DNP, FNP-BC
So that's important because sometimes you don't realize those milder headaches are in there because you're just having the severe part of that and it really takes you down. And those are the ones you remember. So, tracking your headache [days] can be extremely helpful. There are paper, ways to track that. I would have patients just bring in their whole calendar that they would write on. But there are also apps that are out there now that are really helpful as well. So there's multiple different ways to do that.

So the next question is when you come into the provider's office, what's going to happen. Hopefully you've written down your headache history because as we know, providers don't have as much time now as they used to. And so, it's nice to have these answers for them. And these are the kind of questions that they're going to ask; How long is this headache been going on? Can you point to the location of the headache or is there a certain area that that is affected? How long does it last and how often are you getting it? What is the severity? And you could even go mild, moderate, severe.

I had some patients that had a hard time with the numbers, you know, one through ten. So I'd ask them, tell me is that a green light. Meaning you're able to get through your whole day. Is it yellow. It's really slowing you down or is it a red light? You're totally down. You just can't do anything. So that's really helpful for us to figure out where we need to start with treatments as well.

Describing the type of pain is extremely important. And are you having other symptoms? Are you having dizziness with this? Are you having some brain fog or some inability to do the word find or to think clearly? Are you having numbness down an arm or a face, or are you having other issues that are going on? Make sure you write those all down.

[Migraine with] aura doesn't happen in everybody. It happens in about 25 to 30% of patients, and it doesn't happen every time. The most typical aura is visual. And that is where you get that blind spot kind of following you as you go, or the bright blinking lights, or it could be a variety of different things, but it can be visual in nature, and that usually starts anywhere from five minutes to two just before the headache.

And it should last no longer than 60 minutes. If it lasts longer than that, then that is another reason to go and have that evaluated sooner.
And then of course, as I had talked about how many types of headache are you having?

An important one to bring up is family history. Family can have the same types of headaches. Now, they may not have called it migraine. For example, my grandmother called it dizzy spells. My mother said she had headaches. Well, I know they're all migraines and I had them as well, but family history, if it's in the family, then that's reassuring that it's probably a primary headache.

Dr. Karen Williams DNP, FNP-BC
So, then what does the physical [exam] look like? Well, we want to do your blood pressure, we want to make sure high blood pressure isn't part of the headache or to lower the blood pressure, your pulse, respirations and of course oxygen concentration.

And then the provider should look in the back of your eye. It's called a fundoscopic exam. To look at the retina and the optic nerve, to look for swelling back there. If they're not able to do that or they're not able to get a good view back there, maybe sending to optometry or ophthalmology is extremely important to do that.

Definitely want to check for range of motion. Are you having a neck component to the headaches? And then also pushing around on the sinuses, on the jaw and on the different nerve areas.

And then from a neurological perspective, just watching you walk in and making sure you're able to keep your coordination, that you're not having trouble leaning to one side or they may do finger to nose. There are some different neurological exams that we do speech wise. Are you having any halting or are you having any trouble with your speech?

Then checking the cranial nerves. There's 12 major nerves that we have running through our central nervous system. And then your reflex and then others as needed.

So, after all of that's done, the next phase would be three different pathways. And the first pathway is the most common. With that one they're looking at the [medical] history and the physical [exam]. And you're not showing any neurological signs that would give us warning for something else going on.

And they may diagnose you with migraine while your provider can sit down and talk to you about some realistic expectations. And that would include talking about an acute treatment or a treatment to treat those migraines as they start, and then also possibly a preventive treatment, if you're having them [migraine attacks] to the point where they're really disrupting your life. And there's different reasons people choose preventative treatments, and that does not mean you have to be on them forever.

And then, being able to track and assess how those treatments are doing, there may still be a possible referral. Say you're a patient who has some other comorbid issues that may be affecting the number of migraines you're getting. That may be a sleep disorder, it may be anxiety or some sort of mood disorder, it may be some neck issues going on that physical therapy or chiropractic can help. So, there may be some other referrals.

Pathway number two, there may be some atypical signs. And they may consider imaging at that point or additional labs. But you may still be diagnosed with migraine. And again they're going to go through the realistic expectations and look at treatment plans. And then maybe still possible referrals.

Dr. Karen Williams DNP, FNP-BC
And then pathway number three is that urgent evaluation by another provider. That may include going to the ER or getting into another provider much sooner than typical. And then the primary care provider will kind of work in that system as well with ongoing monitoring. Again, maybe possible referrals and then tracking and assessing all of that.

Okay so, stages of migraine, I think this is important. When I first started many years ago, we didn't know about all the different stages of migraine. And I want to start by looking at stage two, which is the prodrome. We didn't know that much about that years ago. And this can occur up to 72 hours before. So up to almost three days prior to the onset of the actual headache pain itself. So, you can have that neck stiffness, you can have that sensitivity to light and sound, that fatigue.

And I want to draw your attention to food cravings. Food cravings were something we always thought were bringing that migraine on. But now we know that may be just some changes that are already going on in your system. They have to do with a major component in your brain called our hypothalamus. And so it can be starting to cause all of that. The nice thing about tracking your migraines is that you can start to catch this early and maybe start taking medication early.

The next phase that starts after that is at aura. And again, that doesn't happen every time, but it does occur in about 25 to 30% of the patients, and that can last anywhere from 5 minutes to 60 minutes beforehand. Then the most typical one is the visual aura that you have.

And then we get into the actual migraine itself. Those symptoms that we talked about before, the sensitivity to light and sound and smells as well, the mood changes, the dizziness, the cognitive issues, the word find issues, all of those different things that we can have. And that can last up to three days itself. So, we're talking almost a week right here.

And then we get into the postdrome. So you're kind of hung over. You still don't feel great. You're still having some difficulty with being able to concentrate. You may still have some nausea. You just feel kind of wiped out.

And then the phases can start all over again with this interictal phase. And this is more for folks who are having those chronic migraines. But it can happen to those with episodic as well. And that interictal phase, it's more about worrying about, oh my gosh, what am I going to get that next attack? When is that going to happen? And that just makes it worse.

Dr. Karen Williams DNP, FNP-BC
Now let's look at prevention. Prevention is something that can be extremely important for folks. It doesn't have to be for everybody, but it is something that a good portion of us want to use. And the idea behind that is, first, we want to reduce the frequency and the severity of the attacks and the disability and then the overall cost of treatment as well.

Again, it also may reduce that interictal phase where you're kind of worried you might be getting that migraine coming up. And so, it's extremely important. We want to also improve the response of the acute treatment to avoid escalation. And then again avoiding maybe medication overuse and improve your functionality and your other health related quality of life.

And then afterwards, what we really hope for overtime is that this gives you empowerment and success over self-management.

Diego Colón
Thank you. Thank you so much, Karen, for that amazing, insightful presentation.

Hey everyone, thank you so much for coming out today and logging on for episode two of Taking Charge of Headache, and we hope to see you again next month on May 16th from 12 p.m. to 1 p.m. Central Standard Time for episode three of Taking Charge of Headache™ Treatment Options Within Military Benefits: What treatment options are available to veterans living with headache and migraine attacks?

Hope to see you there and until then, have a good one.