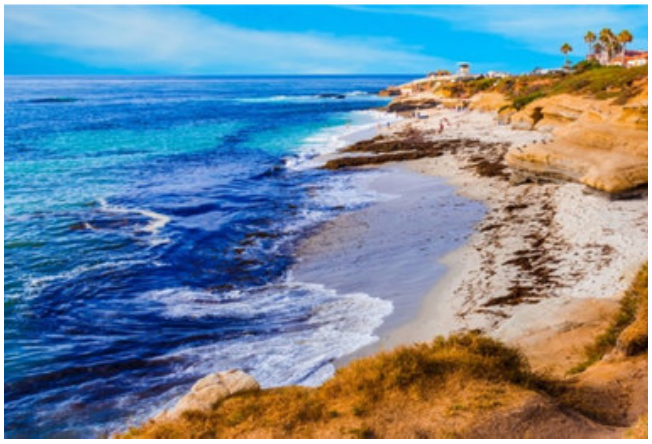
Is there an epidemic of chronic tension type headache in Washington, DC?

Surveys conducted to determine the proportion of headache subtypes typically have demonstrated so-called tension type headache to be the most common primary headache disorder in the general population, closely trailed by migraine.

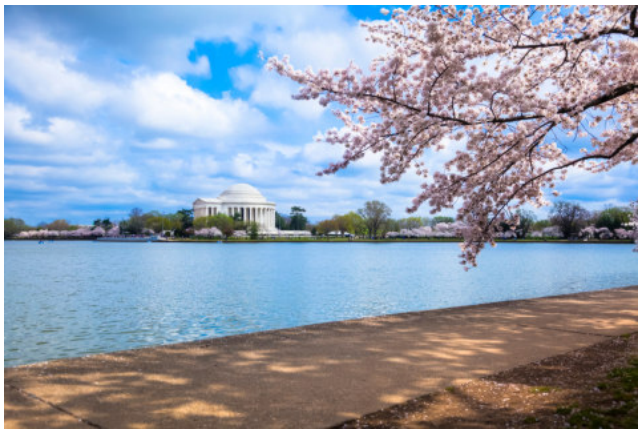


In international surveys the incidences and proportions of the primary headache disorders may differ somewhat from one country to another, perhaps reflecting cultural differences that influence an individual's response to such a survey. In China, for example, investigators have recorded a significantly lower incidence of self-reported migraine, and some have speculated that this result reflects a tendency to minimize one's health problems rather than a true difference in the disorder's frequency. Within the United States, however, the incidences and proportions of the specific primary headache disorders appear to be more or less the same from one region to another.

When one examines the groups of individuals who seek medical attention for their recurrent headaches, however, some interesting regional differences emerge. Studies comparing headache patient populations at university-based headache clinics in the greater San Diego area, Alabama and western Nevada found that the proportions of headache disorders were roughly the same in all three areas, with **chronic migraine** by far the most common diagnosis recorded.

Patients in the Alabama cohort were more likely to have previously seen a medical provider for headache, to previously have had a brain imaging study, to have tried an appropriate treatment for migraine prophylaxis and to have tried a triptan for acute headache treatment. Compared to patients in metropolitan District of Columbia (DC), headache clinic patients in Nevada who had chronic migraine were more likely to be using overusing symptomatic medication and, specifically, more likely to be overusing an opiate or opioid ("narcotic"). Particularly striking, in comparison to greater San Diego, Alabama and western Nevada, there was a much higher proportion of chronic tension type headache (CTTH) in the headache patient population seen at George Washington University in DC.

Why are patients with CTTH so seldom seen in most headache clinics? The International Classification of Headache Disorders criteria indicate that CTTH typically involves pain of mild to moderate intensity that does not significantly reduce one's ability to carry out routine activities of daily living, is not accompanied by nausea or light/sound sensitivity and is not accompanied by the aura symptoms that migraine patients (and medical providers) often find alarming and attribute to other more ominous diagnoses (stroke, warning of stroke, brain tumor, etc.).



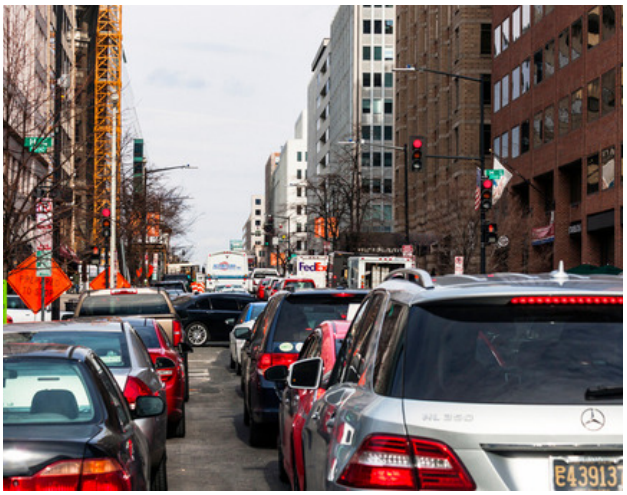
Therapies known to be effective for chronic migraine (eg, onabotulinumtoxin A/ "Botox A") have not been shown to suppress CTTH. Therapies developed for acute migraine treatment (the triptans in particular) do not "work" for acute tension type headache. Amitriptyline remains the mainstay of pharmacologic therapy for suppression of CTTH, and its degree of effectiveness remains as murky an issue as its mechanism of action. Other treatments currently recommended for CTTH suppression (biofeedback, acupuncture) possess little in the way of objective evidence of benefit and may be expensive.

Why does CTTH appear to be so much more prevalent in DC...at least in the university-based headache clinic population? Is it DC's horrendous traffic and long commutes? The relative intensity of urban living? Selection bias that favors high-functioning, ambitious individuals who cannot abide any imperfection that might potentially limit their productivity? The lack of an ocean or good surf?

Our study began in the last 18 months of Mr. Obama's administration and extended into the first years following Mr. Trump's ascension to the Oval Office, so this is at least one aberration that cannot be attributed to the current president.

I can't tell you why I've seen more CTTH in my first 4 years at George Washington then I saw in my previous 20 in other regions of our country, but having lived in and evaluated thousands of headache patients in each of those regions – San Diego, Alabama, Nevada and, now, DC – I do have my suspicions. And they involve what I perceive to be cultural reinforcement of an emotionally and physically unhealthy lifestyle. To counter that lifestyle I emphasize patient-initiated interventions that include:

- Aerobic conditioning
- Meditation and other relaxation techniques that can induce "self-hypnosis"
- Improved sleep hygiene and diet
- Psychotherapy



Such therapies often are not palatable to patients who seek a "quick fix", and to me and my colleagues remains the task of providing clear proof that these (or other) therapies are effective. Four years ago, before coming to our nation's capital, I would have considered this task a low priority. Now, however, with CTTH such a part of my community and my clinical practice, action clearly is required.

JFR