

"Knowledge of the Abord Aje De La Cefalea Tensional by First Contact Doctors at The Regional Military Specialty Hospital In Guadalajara, Mexico"

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1. Summary

Headache is one of the most common reasons for consultation where people go to emergency services. It is estimated that at least one-third of the population between the age of 18 and 65 has ever suffered from a headache. Therefore, the doctor, when confronting a patient with this pathology, must have the ability to differentiate between primary or secondary headache since the latter can seriously compromise the life of his patient. It is also important to identify risk factors, alarm signs, and headache-related diagnostic tools because they could help guide your diagnosis. It is important to keep in mind that although headache has a multifactorial etiology, the role that genetics and molecular biology play in its development is also relevant. Headache becomes a daily challenge for the clinician, as a correct approach to this condition depends on the outcome and quality of life of the patients.

2. Abstract

Cephalaea is one of the most common patient's medical reasons to attend an emergency room. It is estimated that at least one-third of the population between 18 and 65 years has suffered from a headache on some occasion. Therefore, the physician must be able to differentiate between the primary and secondary cephalaea since the latter can seriously menace the patient's life. Likewise, to make the right diagnosis of cephalaea, is very important to identify the risk facts, the warning signs, and the diagnosis tools concerning to it. It is very significant to consider that, although the cephalaea

could have a multifactorial etiology, genetics and molecular biology have a relevant roll in its development. Cephalaea becomes a daily challenge for the physician since a correct approach to this condition fall on the patient's outcome and quality of life.

3. Introduction

3.1. Tension Headache

The most common subtype of primary headache. Pain is typically bilateral, oppressive, and mild to moderate in intensity. No nausea and does not worsen with physical activity. Sensitivity to light, noise or pericrania hypersensitivity may be associated. Tension headache is characterized by pain attacks that are not associated with nausea or vomiting, and have at least two of the following characteristics:

- Bilateral headache
- Non-throbbing headache
- Mild to moderate intensity
- Headache does not get worse with activity, such as walking or climbing stairs

Uncommon episodic tension headache: Rare headache episodes, typically bilateral location, with mild to moderate intensity tensive or oppressive pain and lasting minutes to days. This pain does not worsen with regular physical activity or is associated with nausea, but photophobia or phonophobia may occur.

Uncommon episodic tension headache is characterized by rare

headache episodes, which appear, on average, less than once a month and meet all other characteristics of tension headache.

Frequent episodic tension headache: Frequent episodes of head-

ache, typically bilateral location, with mild to moderate intensity tense oral or oppressive pain and lasting minutes to days. This pain does not worsen with regular physical activity or is associated with nausea, but photophobia or phonophobia may occur.

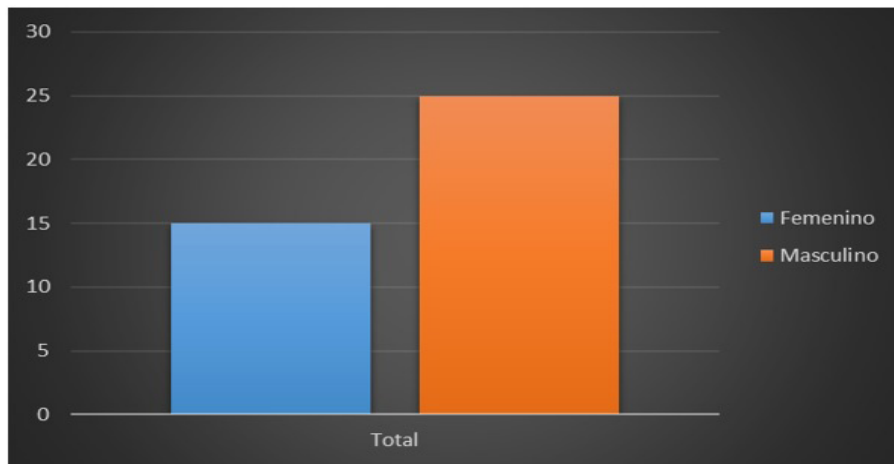


Figure 1: Total Doctors Surveyed (Men And Women)

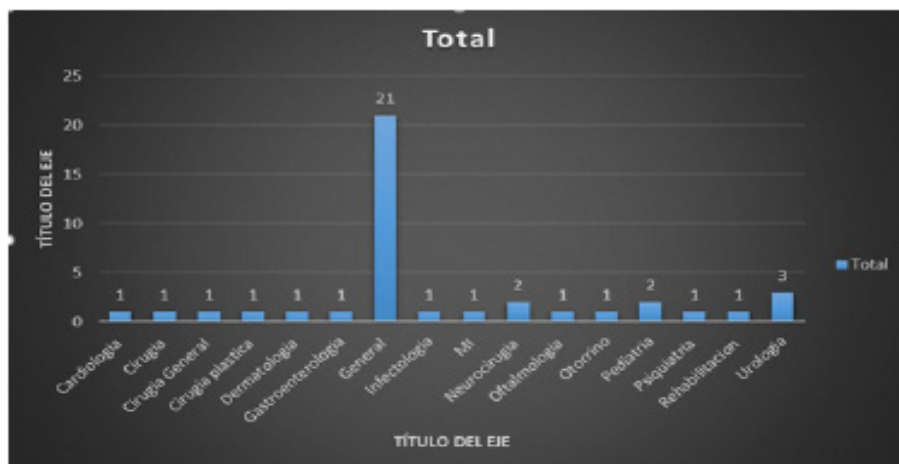


Figure 2: Total Specialties That Participated In The Survey, Not Including General Physicians

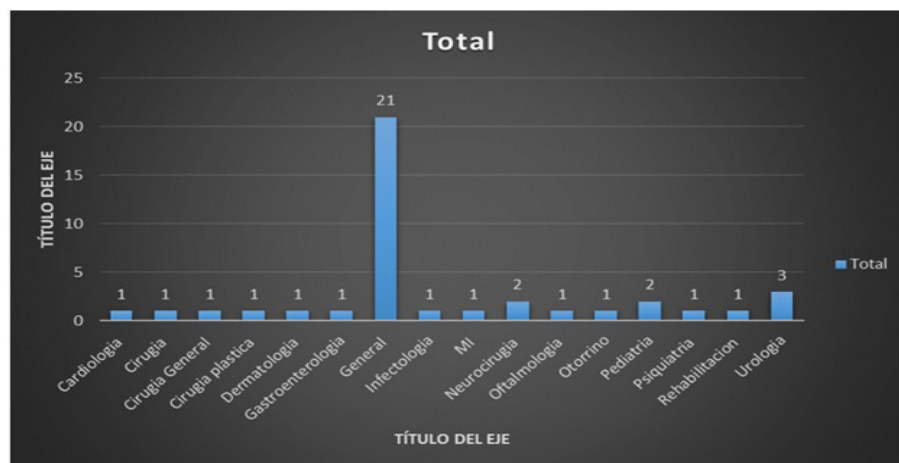


Figure 3: Total Specialties Participating In The Survey With General Physicians

Frequent episodic tension headache is characterized by at least 10 episodes of headache that occur on average, 1-14 days a month, for more than 3 months (> or 12 and < 180 days a year) and meet all other stress headache criteria. Chronic tension headache occurs more than 15 days a month over a period longer than three months. Chronic tension headache should be diagnosed when episodes of headache occur in more than 15 days per month for more than three months and meets the rest of the criteria of tension headache. It is understood by headache [1], the presence of pain located above the line between the two external eye edges, to the center of the external ear canal, pain that originates below this line should

be called facial pain [2]. Simultaneous headache is a symptom and syndrome. When defined as pain in the cephalic limb, reference is made to the symptom. On the contrary, considering it as a syndrome would imply its multicausality and the different types involved.

His path pathology is mediated by two ways. The first, which is the normal physiological response, is generated by the activation of nociceptors in response to tissue injury, visceral distention, and other factors. The second, on the other hand, occurs when there is damage or malfunction in the pain pathways related to the central or peripheral nervous system.

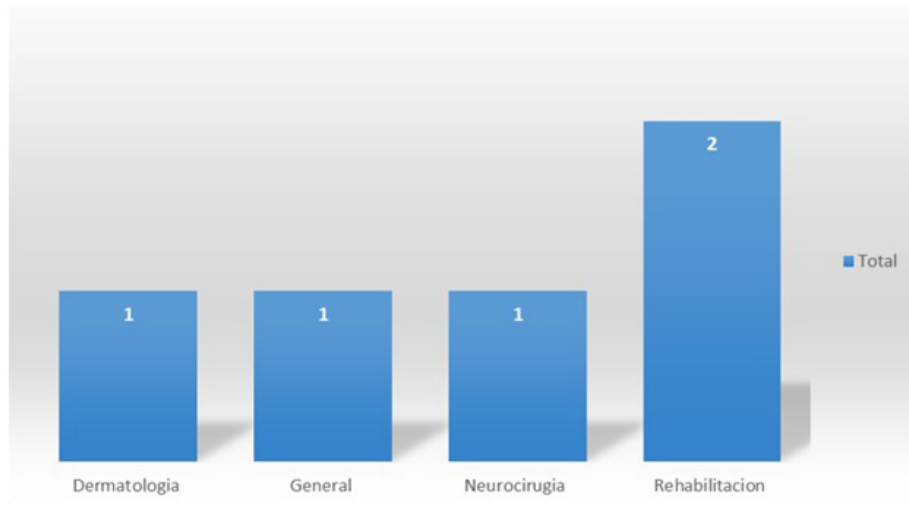


Figure 4: Physicians who requested a lateral spinal radiograph



Figure 5:

Among the structures of the cranial vault involved in the headache process are the venous breasts, the anterior and middle meningeal arteries, the dura mater, the Triestino, glossopharyngeal and vague nerves, proximal portions of the internal carotid and its branches near the Willis polygon, the brainstem, the periaqueductal gray matter, and the nuclei. Extracranial structures also related to headache are cranial periosteum, skin, subcutaneous cell tissue, arteries, neck muscles, the second and third cervical nerves, (C2 and C3), eyes, ears, teeth, sinuses, among others. According to the World Health Organization in its study "Global Burden of Disease 2012", tension headache and migraine appear as the second and third most common diseases in the world, (Murray CJ, 2012) and migraine is clearly the most disabling of primary headaches taking into account frequency and burden of disease. (Lipton RB, 2001) Therefore, it is the most common neurological syndrome that is treated at the first level with 3% of adults who consult each year with their family doctor for this cause, (Latinovic R, 2006) and is the disease that neurologists see most in their clinical practice, according to surveys applied in the United States. It has a lifetime prevalence of about 15% in the general population, and affects women in greater proportion (18%) than men (8%). (Steiner TJ, 2013) It has been called the seventh disabling due to its considerable impact on patients' quality of life. (Steiner TJ, 2013). Headache, as one of the most common reasons for consultation for people attending emergency services, has an adult prevalence of 47%. At least one-third of the population between the age of 18 and 65 has ever suffered from a headache. In children the prevalence is 37 to 51% at 7 years and 57 to 82% between the 7 and 15 years, the higher being in men than in women between the 3 and 7 years, and after 7 years it is equal. After puberty this relationship varies substantially and is estimated to be 3 women per man. Studies in Mexico show that the people who suffered most from headache had as a level of secondary schooling, were married and resided in the urban area, which generates a reflection on lifestyles and their possible association with the development of this syndrome. Within headaches, migraine is predominantly female: women, compared to men, have a prevalence of migraine per year almost three times higher (17 vs. 6%) and the lifetime incidence is almost three times higher (43 vs. 18%). Some studies have suggested that between 3 and 14% of people with episodic migraine patterns evolve into chronic migraine. This type of headache is part of, along with the group's chronic tension headache known as chronic daily headaches (CCDs), conditions that have become important causes of disability and absence from work with an average loss of 7.3 hours of paid work and 7.5 hours of unpaid work, resulting in a total loss of one active workday per month.

Headache, in addition to being a major cause of disability, has consequences on a personal level, since individuals who suffer from it have a continuous fear of the appearance of new episodes, which

often affects their social, family and work activities, thus causing a deterioration in their quality of life.

CLINICAL TABLE. Tension Type Headache (CTT) is characterized by the presence of bilateral pain (most of the time), of oppressive, non-throbbing type, which distinguishes it from migraine, in addition to being less frequent the presence of accompanying symptoms characteristic of migraine, does not increase with physical activity and mild to moderate intensity. Therefore, it could be said that the diagnostic criteria of TTT indicate that the patient does not have migraine. It can occur episodically (<15 days per month or <180 days per year) or chronically (>15 days per month for >3 months or >180 days per year), as well as associated or not with pain of the pericrania musculature Diagnosis is usually made with the criteria of the International Classification of Headaches. Still, not all doctors are familiar with the diagnostic criteria.

Underdiagnosis remains a major problem in daily practice, resulting in incorrect treatment. Various tools have been designed to improve the diagnosis of migraine, to identify the psychological alterations it causes, to measure the burden of disease and disability and to know the reduction in quality of life that occurs due to pain attacks. Among these instruments are the ID Migraine, a test with 3 items, which has been validated in primary care as a way to improve the rapid diagnosis of migraine; the MIDAS questionnaire that serves to assess the incapacity caused by migraine attacks and HIT 6 which is a tool that allows us to measure the impact that headaches have on the quality of life of patients and the severity of pain.

Despite having all these instruments, the proper selection and interpretation of them is crucial so that faster, more accurate diagnoses can be made and that allow us to initiate treatment for patients who are affected by this disease, so that we can give them adequate management and can return to their daily life without suffering affectations in it.

It is vitally important to establish guidelines regarding the treatment of tension headache and migraine because there is great variability in clinical practice with regard to the management of these two entities; it causes individuals who suffer from them to be constantly afraid of the emergence of new episodes and, by not achieving the restoration of health, to be limited to return to their daily activities, with the respective repercussions on their social, work and family environment, generating a deterioration in their quality of life.

4. Approach To The Problem

What is the clinical approach, or cabinet studies for the diagnosis of tension headache at the Regional Military Specialty Hospital of Guadalajara, Jalisco?

5. Justification

The most common reference in the Neurology service are tension

headache and migraine, which can cause substantial levels of disability, not only to patients and their families but to society as a whole, due to its high prevalence in the general population. About half of patients with acute headache have tension headache and 10% have migraine. A migraine attack is a spectacularly complex brain event that can produce a wide variety of neurological and systemic symptoms. Although pain is its most prominent feature, migraine can include a multiplicity of symptoms that occur before, during, and after pain. This makes headaches a daily challenge for doctors; this is why knowledge of their clinical presentation, alarm signs and diagnostic methods is of vital importance, in order to achieve a clinical approach with a view to timely diagnosis and management, so as not to suffer from episodes of headache or disability.

The purpose of this research is to establish a national benchmark to guide clinical decision-making based on recommendations based on the best available evidence.

This guide makes available to staff at the first and second level of care recommendations based on the best available evidence with the intention of standardizing national actions concerning:

- Unify diagnostic criteria of Tension headache and migraine in the first and second level of care.
- Use diagnostic tools for tension headache and migraine in the first and second level of care.
- Offer prophylactic treatment to adult patients with tension headache and migraine at the first and second level of care.
- Implement adequate treatment, using available resources, to patients with tension headache and migraine at the first and second levels of care. This will promote the improvement in the effectiveness, safety and quality of health care, the thus contributing to the well-being of individuals and communities, which is the central objective and raison d'être of health services.

6. General Objective

Define the diagnostic method of tension headache by doctors at Guadalajara Regional Military Hospital, Jalisco.

7. Method

7.1. Study Universe

Formed by military doctors and civilians of the Regional Military Specialty Hospital in Guadalajara, Jalisco.

7.2. Work Area

Regional Military Hospital of Medical Specialties in Guadalajara, Jalisco.

7.3. Study Type

Descriptive survey.

7.4. Study Time Period

April and May 2019.

7.5. Selection Criteria

- Medical staff of the Regional Military Hospital.
- Contact with patients in external consultation, emergencies, or hospitalization.
- Give consent to participate in the survey.

7.6. Elimination Criteria

- Doctors in the area of radiology and imaging.
- Doctors who do not have contacts with patients in external consultation, emergencies or hospitalization.

8. Conclusions

The approach to tension headache is eminently clinical, but cabinet studies, focused mainly on skull tomography, and even more on cervical spine lateral x-ray, so forgotten but so useful and demonstrative of injuries that cause headaches, will always be very important, which should be addressed at the end of the day as a spinal problem.

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