



## Preface

# Headache and facial pain



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*Guest Editor*

At least 23 million people in the United States complain of chronic or recurring headache, and probably three times that number at some time in their lives have used medication for similar symptoms.

This issue of the *Otolaryngology Clinics of North America* addresses the problems of headache and facial pain as they affect otolaryngologic practice. We are assuming the reader's competence to perform an appropriate physical examination that includes a basic neurological examination and familiarity with use of radiologic examinations and chemical laboratory tests. Our efforts are meant to be a practical approach based on the most up-to-date information that is available.

Over the years there has been a bewildering confusion of diagnostic terminology such that more than one, and sometimes three or four, "names" often designate the same entity. In an attempt to simplify diagnostic terms and bring them into line with modern concepts, we have provided an abbreviated version of the classification most recently suggested by the International Headache Society. Although the original classification defines over 300 causes for headache and facial pain divided into eight sections, we have reduced this number to a more manageable and relevant group.

It is virtually impossible to distill the world's medical literature into the confines of this publication. We have, therefore, concentrated on experience garnered in clinical practice. We exhort the practitioner to always be mindful that headache and facial pains are best managed by a multidisciplinary approach that might include anesthesiologists, dental and facial pain

specialists, neurologists, neurosurgeons, nurses, otolaryngologists, orthopedic surgeons, physiatrists, physical therapists and psychologists.

Many people who suffer from headaches and facial pains are seeking, and finding, relief in alternative remedies, such as acupuncture, biofeedback, and meditation. This indicates that not all of our efforts are successful, prompting patients to seek alternatives. In a study of over 70 adults attending a pain clinic in New York, 85% employed alternative therapies to relieve their pain, and 60% of them believed the therapies were effective. The recently described phenomenon of rebound headache now places an even greater burden on the shoulders of the practitioner who must be constantly aware of the possibility that the medications he/she prescribes can, after a while, be the cause of continuing symptoms.

The management of headache and facial pain is expensive, costing over \$1 billion annually in the United States alone for medications, and up to \$13 billion if the cost of lost workdays and reduced productivity are factored in (*Business Week*, August 26, 2002, p. 146). The cost of alternative therapies is difficult to assess but probably equals or exceeds that of prescribed treatments. The expenditure escalates annually with succeeding generations with no end in sight. The real efficacy of many of the leading alternative remedies still remains unstudied, but the public continues to be bombarded daily by advertisements in the lay and even the professional press about the wonders of substance A or substance B. This is obviously a lucrative market.

As expected, so common a problem with such diverse forms of management is a magnet for quackery, which is rampant even to the point of witchcraft. The public can be extraordinarily gullible when it comes to the treatment of chronic pain, be it real or imagined. The physician's role therefore must be both therapist and guidance counselor. The section on alternative therapies is not designed to be comprehensive but serves to inform practicing physicians of the various forms of treatments that are available, most of which their patients use at one time or another.

It is our hope that this small volume will be a practical guide in clinical practice and stimulate more awareness of and interest in the management of headache and facial pain.

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