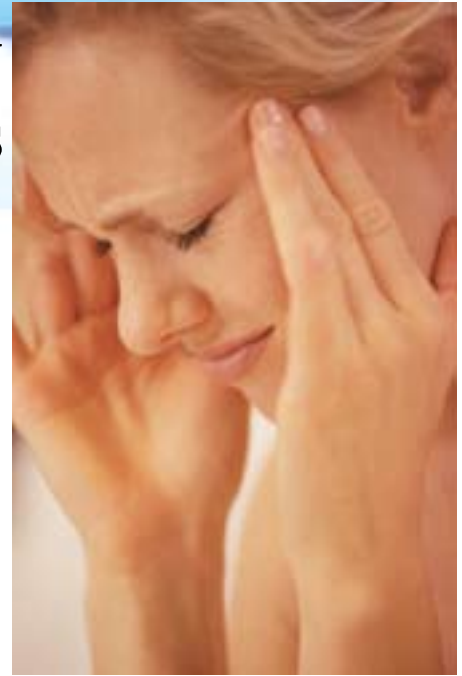




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Headaches: How to Quickly Identify Trigger Points



Commonly when trigger points refer into the head the patient describes the phenomena as a “headache”. It is difficult to memorize the individual pain patterns for each muscle and doing so can give any therapist a headache. This article will review common myofascial trigger point (TrP) patterns that exist to ensure they are not overlooked, thereby increasing your effectiveness when treating patients with headaches. Trigger point patterns have been extensively studied and the referral patterns are well documented.

To help you work efficiently, educate your patients and impress them with your unlimited knowledge I have included an additional page listing all the muscles you need to check. I also included a few illustrations to simplify the process of identifying trigger points associated with headaches.

Lets look at a few illustrations to better understand the patterns and dysfunction associated with them. The box labeled “Sternocleidomastoid 1” shows the referral pattern for the sternal division of this muscle. This pattern is readily misdiagnosed as a vascular headache or atypical facial neurologia.¹

The box labeled “Sternocleidomastoid 2” shows the referral pattern for the clavicular division of this muscle. Patients with trigger points in this muscle commonly experience frontal headaches and earache. Referred autonomic phenomena are more likely

to involve the forehead and ear, including dizziness. This dizziness is usually described as a movement or sensation within the head and less often of vertigo, the sensation of objects spinning around the patient, or of the patient spinning.²

The box labeled “Splenius Cervicis” shows the referral pattern for this muscle. Pain from this muscle is projected upward to the occiput, diffusely through the cranium, and intensely to the back of the orbit often described as an “ache inside the skull.” Sometimes, splenius cervicis pain is referred downward to the shoulder girdle and to the angle of the neck. Referred phenomena could include headache and/or neck pain with unilateral blurring of vision.

Here is an example of how to integrate this information into your practice. A patient enters with primary complaints of severe headaches in the temporal and vertex regions, specifically mentioning pain behind the left eye. Secondary complaints include moderate cervical pain with a slight restriction of cervical range of motion.

Before starting the initial treatment, show your patient the trigger points you must check and treat based on their subjective complaints. You could show them the attached page I made so they understand where and why you will be treating certain muscles that are nowhere close to their headache. Let the patient know that you are designing a

specific treatment plan that is tailored to their specific symptoms. You could copy of the illustration page and circle the trigger point patterns associated with their pain. Follow the instructions on the bottom of the attached page and check all the muscles that may contain trigger points.

Integrating these simple tools and techniques can increase the financial bottom line of your practice when pain free patients who are impressed with your knowledge and commitment to excellence refer you more clients.

David Kent, LMT, NCTMB is an international lecturer specializing in Human Anatomy Dissection, Medically Oriented Deep Tissue/Neuromuscular Therapy (NMT), Postural Analysis and Practice Building seminars. David is an innovator and has developed the Postural Analysis Grid Chart™, Trigger Point Charts, Personalized Essential Office Forms™, Videos and DVDs. To learn more about David visit www.DavidKent.com or call toll free (888) 574-5600.

References:

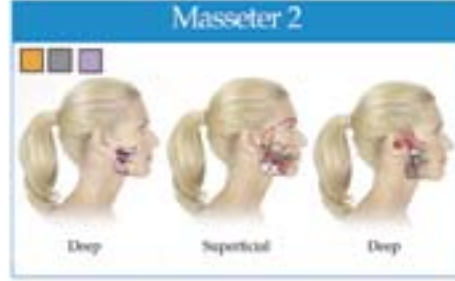
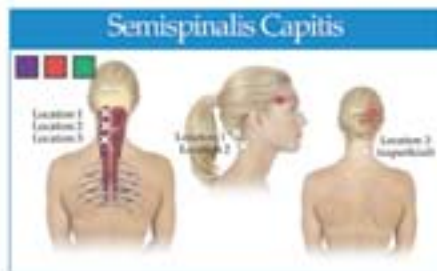
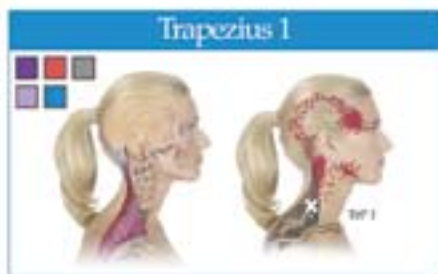
- 1 – Travel J: Identification of myofascial trigger point syndromes: a case of atypical facial neuralgia. Arch Phys Med Rehabil 62:100-106, 1981.
- 2 – Weeks VD, Travell J: Postural vertigo due to trigger areas in the sternocleidomastoid muscle. J Pediatr 47:315-327, 1955.

Pain Referral Areas



- VERTEX PAIN**
Sternocleidomastoid (sternal), Splenius capitis
- BACK OF HEAD PAIN**
Trapezius (TrP1), Sternocleidomastoid (sternal)
Sternocleidomastoid (clavicular), Semispinalis capitis
Semispinalis cervicis, Splenius cervicis, Suboccipital group,
Occipitals, Digastric posterior belly, Temporalis (TrP4)
- TEMPORAL HEADACHE**
Trapezius (TrP1), Sternocleidomastoid (sternal)
Temporalis (TrPs1,2,3), Splenius cervicis, Suboccipital group
Semispinalis capitis
- FRONTAL HEADACHE**
Sternocleidomastoid (clavicular)
Sternocleidomastoid (sternal), Semispinalis capitis
Frontalis, Zygomaticus major
- EAR AND TEMPOROMANDIBULAR JOINT PAIN**
Lateral pterygoid, Masseter (deep)
Sternocleidomastoid (clavicular), Medial pterygoid
Suprahyoid*, Infrahyoid*, Longus capitis*,
Longus Colli*, Palatini*, Palatoglossus*

- EYE AND EYEBROW PAIN**
Sternocleidomastoid (sternal), Temporalis (TrP1)
Splenius cervicis, Masseter (superficial)
Suboccipital group, Occipitals
Orbicularis oculi, Trapezius (TrP1),
Suprahyoid*, Infrahyoid*, Longus capitis*, Longus colli*
- CHEEK AND JAW PAIN**
Sternocleidomastoid (sternal), Masseter (superficial),
Lateral pterygoid, Trapezius (TrP1)
Masseter (deep), Digastric, Medial pterygoid, Buccinator
Platysma, Orbicularis oculi, Zygomaticus major
- TOOTHACHE**
Temporalis (TrPs1,2,3), Masseter (superficial)
Digastric (anterior)
- BACK OF NECK AND SHOULDER PAIN**
Trapezius (TrPs1,2,3) Multifid, Levator scapulae,
Splenius cervicis, Infraspinatus 1*, Longus capitis*,
Longus colli*, Scalenus
- THROAT AND FRONT-OF-NECK PAIN**
Sternocleidomastoid (sternal), Digastric, Medial pterygoid
Suprahyoid*, Infrahyoid*, Longus capitis*, Longus colli*



Instructions: At the top of the page is a box labeled "Pain Referral Area" within this section locate the colored areas associated with the client's pain and/or discomfort. The muscles listed with each colored area may have trigger points that commonly produce referred phenomena (headache, pain, tingling, burning, numbness, etc.) into the colored area. Each muscle associated with the colored area should be thoroughly treated to determine if trigger points are present. Generally muscles are listed in order of involvement, superficial to deep, and to help the therapist to quickly rule out distant trigger points. The patient's subjective complaint(s), the therapist's objective findings / assessment and how the therapist positions the patient during treatment may alter the order of the treatment.

Each muscle box has colored blocks corresponding to the colored areas in the section labeled "Pain Referral Areas" These colors are a quick reference for the patient and / or therapist to identify the muscles, trigger point locations and specific referral patterns.

"X" indicates the location of common trigger points and red indicated the common referral zones based on the research of Drs. Simons and Travell et al.

David Kent
EDUCATION

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