Literary Review

Review of: Oral behavioral patterns in common migraine, by Robert A. Moss (1987)

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ORAL BEHAVIORAL PATTERNS IN COMMON MIGRAINE

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Two kinds of migraine headaches have been described in the literature. Classic migraine is always preceded by visual prodromal changes; whereas, common migraine has no such distinction. For years, a common vascular etiology has been postulated for both types of migraine. Newer research, however, suggests differing causes for the two kinds.

Both the visual aura and bloodflow changes have been found in patients with classic migraine, but neither of these symptoms have been noted in patients with common migraine. A different symptom, muscle tenderness in the head, neck, and/or face, has been found to occur with common migraine. Also, altered sleep duration seems to accompany classic migraine, but not the common migraine headaches.

Striking similarities have been noted in the age and sex data for temporomandibular joint (TMJ) dysfunction and for migraine (the large majority are women with a typical age onset of approximately 20 years). Four oral behavior patterns, diurnal bruxism or clenching, thrusting the jaw forward, cupping the chin in the hand, and resting the hand on the side of the face) have been found in both the migraine and TMJ dysfunction groups. Since common migraine, with its accompanying head/neck muscle tenderness, is diagnosed in approximately 85% of all migraine patients, there is a possibility that patients with common migraine and those with TMJ dysfunction may

reflect the same population. It also seems possible that reducing the oral behavioral patterns should decrease the headache pain.

Moss describes four common migraine cases with severe headaches who were given oral "habit reversal" therapy. Treatment procedures included identification and heightening awareness of the oral habits, production of an incompatible response (for instance, closed lips and relaxed jaw together with separation of upper and lower teeth; or placing the hands in the lap, rather than on the face or chin) for 30 seconds immediately following each oral habit episode, and practice of the incompatible responses for two, five-minute periods daily.

Excessive TMJ strain had preceded the headaches in three of the cases. All four demonstrated TMJ sounds and high rates of oral habits. Two were asked to clench their teeth hard during assessment. They induced headaches after less than five minutes of teeth clenching. Sleep patterns for all four patients were unaltered. All four reported improvement during treatment.

Moss suggests that habit reversal therapy may serve as a useful adjunct for treatment of both common migraine patients, and those with facial pain. Based on prior studies, he also advocates that relaxation training be incorporated into the treatment. The patient should gain immediate benefit from these procedures.

REFERENCES

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