

*A thorough analysis and good case history are of prime importance in locating causes of headaches*

# Case History For The Headache Patient

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Optometric case histories today range from a small card containing name, address, age, telephone and credit references, to a lengthy, unwieldy mass of unrelated data which is burdensome to the patient, and many times, meaningless to the practitioner.

In the days when the vision specialist treated an eye as though it were a camera, and the extent of all therapy was only to clear the focus of each eye individually, a practitioner merely sought the same information from each patient, thus relieving him of the responsibility of taking a case history.

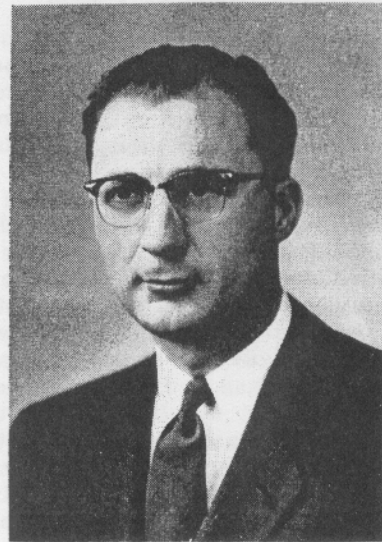
Today, however, the scope of the vision specialist has widened to encompass such a broad concept of vision and service to humanity that his investigations must, of necessity, reach into allied fields. Much stress has been laid in recent optometric and medical literature upon the fact that vision is a very dominant act of a being, controlling the very development of the organism. Vision is an integrated activity bringing into play all other senses. Therefore, it is so interwoven within the scope of all organismic activity, that many times the optometrist is consulted, when in reality, the problem is outside his sphere. Conversely, many patients go from physician to physician and make a continual round in an effort to solve a problem which rightfully belongs to the vision specialist.

A thorough analysis is essential, but it cannot take the place of a good history. This is true, not only for the optometrist, but for the physician as well. Too often today, rather than bother with a thorough history, the physician relies too heavily upon the diagnosis coming from a laboratory technician. Many problems could be solved by consultation only, rather than by lengthy laboratory tests.

A routine optometric visual analysis today investigates many facets of the whole seeing act. As new techniques are developed and standardized, the practitioner is more and more prone to rely too heavily upon the analysis of these tests, rather than to spend additional time in history-taking and observing the patient. We also find that with the development of these tests, more men are conscientiously endeavoring to perform the best service possible by seeing how many tests they can run on each individual. Thus their work becomes strictly a mechanical procedure. The level of

professionalism with them is determined by the battery of tests and skills used.

*All patients should not be handled the same way.* What is a complete analysis for a man of forty-five years of age in good health, just entering presbyopia is not a complete analysis for a patient complaining of chronic headache of severe intensity whose whole personality has been changed due to the resultant neuroses.



Dr. Raymond R. Roy  
*the headache diary*

Yet today, we find optometrists whose whole routine is a standardized procedure from which there is no deviation. If this procedure is directed to the difficult patient, then it is burdensome and wearisome to the patient with a simple problem. It is an insult to a man's intelligence and professional discretion to become so mechanical that every patient receives identical care.

## The Case History

What is true of the visual analysis is likewise true of the type of history and length of history to be taken. It should never become mechanical, but should be suited to the needs of the case.

Referring again to the man in good health with an early simple presbyopic problem, you would not subject him to a third degree type

of history. This would be an unutterable waste of his time and yours. What need have you to inquire deeply into his past medical history, his family's history, his personal problems, his home life, social problems, etc.? Surely he would feel that you were violating a sacred trust which is yours as a professional man.

However, the problem of too extensive a case history is certainly a rare one indeed in the professions of optometry and ophthalmology, so it will not be dealt with in this discussion. The problem in these groups lies with those taking little or no history, or one which is aimed purely at the local region of the eye itself. When the patient reveals that his predisposing problem is headache, then the vision specialist should be alert and prepared to take a more extensive history. The purpose of this article is to be somewhat of a guide in dealing with this specific problem.

### The Headache Patient

Riley is quoted as saying, "If one should search for the human ill which has manifested itself most widely during all times and among all people, there can be but little doubt that headache would attain this unenviable distinction."

Sluder wrote, "Recurrent headache when at all severe (or even when slight) in the course of time becomes a matter of serious moment for the individual; and with the higher grades, is the cause of so much disaster both in his affairs and to the general welfare of the family, that from the earliest times to the present hour it has had the serious efforts of some of the best minds bestowed upon the solution of its causes and treatment."

Add to this observation an interesting bit of information pertaining to the relationship of headache to sight as given by Walton. He found that of those who were totally blind from birth, or blind in one eye, sixty-six per cent were free from headache, while in marked contrast, only thirty-one percent of the individuals with binocular vision did not suffer from headache.

Moench says that, "Eye strain is one of the most common causes of headache. The lay mind is so convinced of this simple aphorism that the ophthalmologist, oculist, and optometrist are usually the first to be consulted by the person with a headache."

Now consider the fact that each year in these United States, people spend nearly \$50,000,000 on headache remedies. This figure is for the analgesics purchased, and does not take into account the professional services rendered to the headache sufferers. Nor does it take into account the tremendous amount of money spent on therapeutics that permanently relieve the pain of headaches.

To the above record, we might add the very brief history of a lady in a neighboring town

who recently took an overdose of sedation one evening and left a note telling her people not to worry. Her worried family discovered her about 3 a.m., rushed her to the hospital, and fortunately were able to save her life. When they found her, she had a note pinned to her bosom stating that she did this act in desperation over chronic migraine headaches for which she could find no relief. She chose this, rather than endure a lifetime of migraine for which she thought there was no cure.

From the above observations, we can conclude that the optometrist must, of necessity, learn more and more about the headache patient, for it can be proven that visual therapy alone can make great inroads into this vast "lost battalion" of headache sufferers. A man who desires specialization in the field of vision has a solemn obligation and duty to humanity to become a headache consultant and to exhaust every etiological possibility within his scope, and then to go even beyond this by referring the patient to men in allied professions who will take a like interest in these people.

### Taking a History

Before going into the specific information which should be taken from a patient suffering from chronic headache, let it be said that this article is merely a guide to some very specific information; *it is not intended to be a stereotyped history for every practitioner.* There are no two men who will take an identical history. Therefore, if you feel that some bit of information which you habitually seek is not included herein, *then continue to take it.* If, however, this contribution will offer any added helpful information that you are not now taking, then its purpose will be accomplished.

Figure 1 is a sample of a concise history form, which is page two of a four-page history and analysis sheet used in my office. It is generally revised with each printing, and this is the current revision. This form is 8" x 6" and folds over into a compact 4" x 6" size to fit into an appropriate filing cabinet. Thousands of these records can be kept in a very small office space.

The history page is divided into four parts: (1) General ocular history, which can be recorded by circling the complaint and writing short explanations immediately following. (2) Fourteen rows of blank lines for writing in full the history which is not covered elsewhere, or to comment more fully on certain phases of the symptoms as they are brought out in the interrogation. (3) The medical and dental history. (4) That phase of the history specifically relating to headaches. In part 1, when a patient states that he suffers from frequent headaches, the word "headaches" is circled, and then immediate attention is placed on part 4.


CASE HISTORY: Headaches		Asthenopia: burn, ache, tire, itch	
Blur: Far, Near	Granulation	Hordeola	Drawing
Conjunctivitis	Muscae Volitantes	Lacrimation	Nervous
			
Medical History:			
Physician:		Oral:	
HEADACHES: Intensity: Primary 1 2 3 4 5		Secondary 1 2 3 4 5	
Circle Primary. Underline Secondary.	Location:	Very Severe	5
	Frontal, temporal, fronto-temporal, occipital,	Average	3
	cervical, parietal, vertex, intraocular, <u>postocular, bilateral, unilateral</u>	Light	1
Time: Onset		Duration:	
Frequency: Constant, Periodic:			
Secondary: Vertigo (light, severe), nausea, vomiting, photophobia, diplopia			
Follows: Reading, sewing, driving, sunlight, movies, no reason			
Seasonal: Summer, Winter			
History:			

Figure 1

### Headache Location

The first thing one wishes to know about a headache is its location. On the history outline in Figure 1, there are listed the most common head locations, each of which can be merely circled or underlined, depending upon primary or secondary degree. Many times one area will be both circled and underlined, as both primary and secondary type pain are located there. In these cases it will be interesting to note eventually whether the primary and secondary headaches are of different etiology, or of one etiology, but merely differing in degree of intensity.

Upon inquiring as to location, one must often guide the patient by demonstrating the various locations on his own head. Do not use technical terminology, but speak in his terms and thus prevent any confusion on his part. In some cases you will find people who have lived with a constant headache for so long, that they find it impossible to locate accurately the seat of the pain. Sometimes they will say it is "all over." For these people, and others who have paid little attention to time of onset, etc., we have developed the headache diary. It will be thoroughly described in this article.

When the headache pain involves the maxil-

lary bone, teeth, mastoid, ear, etc., is usually described in writing, rather than on the outline, since there should be some added clarification.

The cervical area is included in the headache location, as so often this post-cervical tension is a part of the headache syndrome. When mention is made of this post-cervical tension, it should be noted whether this extends downward and fan-wise into the trapezius area as well. In some instances this pain, or "tension," as it is called, will also refer down one or both arms.

### Warning

There is one very important fact about headache location which should be noted most carefully by all who deal with the headache patient, and that is that *the location of the headache is not a reliable guide as to the etiological factor involved.* So many articles on headache diagnosis make an attempt to standardize the diagnosis due merely to headache location. This is definitely a poor practice, as it can easily lead any practitioner astray, and tends to close his mind as to a different possible cause.

A recent article in THE OPTOMETRIC WEEKLY attempts to epitomize ocular headaches into

six types or syndromes, with a very brief location description of each. For example, the author states that vertical muscle imbalances produce a supraorbital headache with a tension and pulling effect. In a recent article, "Ocular Migraine and Prolonged Occlusions," THE OPTOMETRIC WEEKLY, September 3, 1953, I attempted to show that headaches of ocular origin, especially those whose etiology is vertical muscle imbalance, can be located in any known area of the head, neck, and shoulders. They can come on at any time of the day or night and follow any pattern. They can also be bilateral or unilateral. In dealing with thousands of chronic cephalalgic patients, I find that ocular headache can emulate any other cephalalgic syndrome. It is the champagne-like quality of ocular headache which in the past has caused the vision specialist to pass up many an opportunity to relieve suffering humanity.

### Headache Intensity

In the headache history (Fig. 1) there is a place for recording the intensity of a headache by a number system. There is provision for recording the primary headache and the secondary headache. First we shall deal with the numerical consideration.

The intensity of the pain is a guide, not to the magnitude of the etiological factor, but to the pain threshold of the individual. Many cephalalgias of No. 5 intensity have been relieved with one diopter of vertical prism. This difference in pain threshold is a very important consideration to the headache consultant.

In dealing with humanity, and carefully interrogating all patients as to possible head pain, one will find that some people have never experienced a headache. They honestly have no concept of what is meant by the term headache. Other people have experienced a mild headache upon a few occasions during their lifetime, while others suffer frequently or chronically with it. Therefore, if a person who has seldom, if ever, experienced cephalalgia, begins experiencing a No. 1 or No. 2 intensity headache with regularity, it most certainly should be given the careful consideration of the No. 4 or No. 5 intensity of the patient chronically predisposed to head pain.

To outline the various degrees of head pain to a patient is a quick and simple task, and it is surprisingly easy for anyone to tell you quickly what range of pain he experiences. This is done in the following manner:

#### Intensity—

- 1—A very mild background pain which could be forgotten if the attention is directed to some interesting activity, yet remains when this activity ceases.
- 2—A mild pain which cannot be forgotten regardless of activity, but will not necessitate medication.

- 3—An "average" headache which normally can be relieved by aspirin, anacin, bufferin, etc. It is almost a necessity to seek medicinal help with this degree of pain.
- 4—A severe pain requiring much heavier sedation or analgesic such as codeine-emperin. With this intensity the patient can still work, but is most uncomfortable and must "drive" himself. There may be secondary symptoms such as: nausea, vomiting, vertigo, photophobia, etc.
- 5—An extremely severe pain requiring bodily immobility. With this pain the patient is bedfast. There may be severe vertigo, nausea, and vomiting. It may be referred to as the "atomic-bomb" variety.

### Primary and Secondary Cephalalgia

In analyzing headache diaries kept over a period of time, and in recording a careful history, it can be soon realized that many patients have two kinds of headaches, one occurring more frequently than the other. For example, the person may awaken every morning between 3 and 5 a.m. with a No. 4 or No. 5 intensity headache, which is dispelled by about 10 a.m. or 12. Perhaps two or three

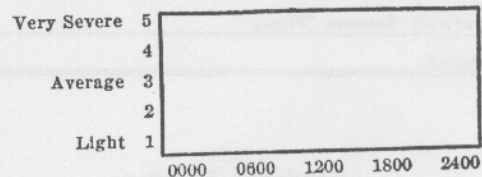


Figure 2

days a week this same person may have a No. 2 or No. 3 headache originate from about 2 to 4 p.m., and increase in intensity as the day progresses. In this case the primary (most common) headache would be the No. 4 or No. 5, and would be so indicated in the history. The secondary would be the p.m. No. 2 or No. 3 intensity. By keeping an accurate headache diary during the period of testing and therapy, the practitioner and patient alike may know whether a particular therapy is affecting the primary or the secondary headache, or both. The location of each is recorded, by circling the location of the primary and underlining the location of the secondary.

It is most important to determine both the primary and secondary headache, and to make the patient realize this difference, or else he will report that the headache still remains, when in reality, either the primary or secondary may have been successfully treated. These cases of multiple etiology are most complicated, and demand the closest cooperation between practitioners with different specialties.

### The Intensity-Time Graph

A valuable aid to patient and practitioner alike is the intensity-time curve of the headache.

As can be seen in Figure 2, this graph is arranged with the abscissa representing the hours of a day, beginning at midnight 0000 and extending to midnight 2400. The ordinate represents the intensity of the head pain as before outlined.

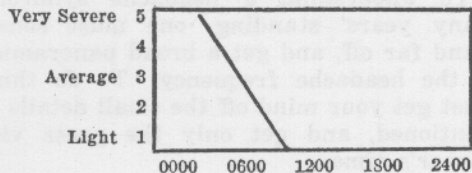


Figure 3

Figure 3 is a diagram of a typical morning headache, which is the type awakening the patient somewhere between 0300 and 0500 with a No. 4 or No. 5 intensity, then gradually receding until it is dispelled by 1100 or 1200. This type differs from the morning headache illustrated in Figure 4, in which case the headache does not awaken the patient, but is present upon awakening, and is less severe in intensity. It, too, gradually decreases in intensity until by 1000 or 1200 it is gone.

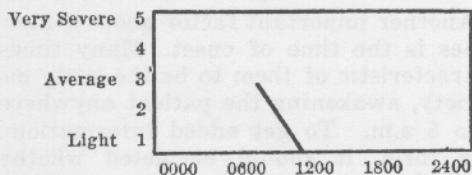


Figure 4

This significant difference in morning headaches is important to note, as the former type can be more indicative of the headache of brain tumor, histamine, glaucoma, or ocular migraine, while the latter can be more indicative of hypertension, sinusitis, or visual fatigue due to prolonged near-tasks the evening before.

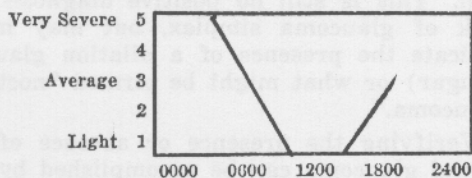


Figure 5

Figure 5 represents multiple headache, illustrating the primary as the severe morning variety causing the patient to awaken, and the secondary as the afternoon variety which perhaps never exceeds the No. 3 stage.

If this graph is used on your records, the primary syndrome can be drawn in one color and the secondary in another for easy differentiation.

### Time of Onset

Some discussion has already shown the importance of knowing the time of onset of a headache. To know whether the headache comes on in the early morning hours, the moment the person gets out of bed, before noon, afternoon, or in the evening is very significant to the practitioner. I believe this to be of more importance than the location of the headache, as experience in dealing with ocular migraine reveals that headache location is no reliable guide to etiology.

Naturally, along with the time of onset, would come other information. For example, a person can awaken in the morning with a headache after having done considerable near-point seeing the night before. If this fact is consistently noted by the patient, then it is a reliable guide to an etiology of visuoneurasthenia.

The duration of the headache should be noted, as to hours, days, or weeks and if the cessation of the pain was a result of analgesic or sedation pharmacotherapy.

### Frequency

The frequency with which the patient experiences a headache attack is a good guide to etiology. Again it is very helpful to know about emotional, dietary, or activity changes just preceding the onset.

When a patient says he suffers a migraine attack perhaps once in six months and in between is entirely free of head pains, the practitioner may rest assured this is rarely of ocular origin. If the complete description of this form would follow the classical description of migraine, this in itself would assure a diagnosis of migraine simplex. If the headaches are constant, night and day, we may look for multiple etiology. Yet a single etiological factor should not be excluded.

If the patient experiences head pain two, three or four days a week, and very thorough physical testing has uncovered no causative factor, then the probability of visuoneurasthenia being the problem, is extremely high.

### Secondary Symptoms

Many writers have expressed the view that severe headaches which produce secondary symptoms of vertigo, nausea, vomiting, malaise, cervical and trapezius tension, etc., are not headaches resulting from the fatigue of ocular dysfunction. This, most emphatically, is a misconception, in that ocular migraine generally produces some or all of these secondary symptoms. In some instances, a secondary pain or symptom may be as annoying to the patient as the headache itself.

In those cases which describe frequent vomiting as an integral part of the case history, a qualifying description should be noted about the vomiting. Is it an act of vomituration, or

is it a very forceful ejaculatory type of emission, sometimes called projectal vomiting? If the latter case is true, then an intracranial lesion should be suspected, and every test needed to exhaust that area should be utilized.

Vertigo is a very common secondary manifestation of ocular migraine, and in some instances can almost be the primary complaint. The most extreme illustration of this was a woman, who for three years previous to our prolonged monocular occlusion routine, was suffering such a severe vertigo that she never was allowed to leave the house without an escort. She had been studied by some sixteen physicians, including two ophthalmologists, none of whom found any etiological factor. Following our complete case study, prolonged monocular occlusion, temporary prism lenses, six weeks of visual training, and permanent prism lenses for both hyperphoria and exophoria, she was completely freed of this troublesome vertigo, and has been completely free for almost four years. There has been no recurrence of the vertigo as long as the prism correction is properly aligned before the eyes.

Photophobia is almost invariably a secondary manifestation of ocular migraine, and is also a frequent complaint in any binocular dysfunction, even though the symptom syndrome has not reached the proportion of migraine intensity. Where photophobia is an integral part of the patient's complaint, it is beneficial to include a tint in the final lens prescription.

Diplopia is rarely noticed by patients with latent phorias, regardless of degree, but more frequently can be noted in cases of high manifest phorias. Usually the diplopia has been noted in patients with a convergence insufficiency when they have attempted to read or perform some near-point task. When a patient describes diplopia during night-driving, the first suspicion is a reflected second image from the car windshield or from the patient's lens correction. If these "ghost" images are from a patient's lens correction, they can be greatly reduced by lens coating. Therefore, we see that merely to record diplopia without further qualification can be misleading.

#### Headache Following Activity

When a patient has noted over a period of time that the headache always follows some specific eye task, it aids in a diagnosis of an ocular dysfunction. Naturally, the headaches which follow reading, sewing, movies, television, driving, etc., have long been recognized as headaches of ocular fatigue, and have made the search easier for both patient and doctor. Most patients have realized this, and when they have realized the consistency of such a syndrome, they usually begin with the optometrist or ophthalmologist in their search for relief.

It must be noted here that some people who are photophobic will develop a headache after being out in the sunshine for too long a period, or who go to the beach or mountains for a day, when their normal activity finds them indoors under artificial illumination. These people may obtain relief from their headaches solely by photophobia control, with dark lenses worn while in sunlight.

#### Seasonal Headaches

To understand a headache syndrome of many years' standing, one must sometimes stand far off, and get a broad panoramic view of the headache frequency. To do this, you must get your mind off the small details aforementioned, and get only the gross view of a year's time.

Some patients will suffer headaches in the wintertime, but be comparatively free of summer headaches, even to complete absention. Conversely, some express headaches beginning in the early spring and carrying on during the summer months, and are comparatively free of them in the winter months.

When a patient complains of winter headaches, he should be questioned carefully about his near-point visual activity during the winter as compared to the summer. This type of headache is frequently seen in students who do little near-seeing during summer vacation.

Another important factor about winter headaches is the time of onset. Many times it is characteristic of them to be the early morning variety, awakening the patient anywhere from 3 to 5 a.m. To get added information about this form, it should be noted whether the headaches are more severe in intensity or more sure to be present if the patient retires early the night before. If this is true, and if the patient can be free of this early morning pain by retiring late, then a strong suspicion of glaucoma simplex can be established. Yet if patients exhibiting a classical syndrome of this type are referred out for provocative tests, there may come back a reply that tensions were normal, before and after provocation. This is still no positive diagnosis of a lack of glaucoma simplex, but may merely indicate the presence of a dilation glaucoma (Sugar) or what might be termed "nocturnal glaucoma."

Verifying the presence or absence of nocturnal glaucoma can be accomplished by having the patient sleep under a 10-watt frosted night light for a period of up to three months. If this fails to eliminate the early morning headaches, then dilation or nocturnal glaucoma could be ruled out. If the light consistently gives relief from the headaches, then a diagnosis of nocturnal glaucoma can be assured, and the night light should be continued. In this event, periodic observation for glaucoma simplex by means of tonometric

readings and provocative tests should be made.

Another factor of winter headaches to be carefully investigated, is the possibility of an inhalant type of allergy resulting from the fumes of a circulating heater. There is also the morning headache after a cold winter night resulting from a lack of fresh air in the bedroom. Some people will keep the window closed and the heat going and will have the headache as a result of heavy CO<sub>2</sub> concentration. Your history will help to delineate these various etiological factors.

In the event the headaches range from No. 3 to No. 5 intensity, and are evident during the spring and summer months only, then allergy should be suspected and the patient referred to a specialist in that field. If the headache intensity ranges more from No. 1 to No. 3 while outdoors or after driving, then photophobia may be suspected, and dark lenses tried experimentally for a short period of time.

#### History

The length of time that the patient has suffered from headache is a most important bit of information for any practitioner who is making a headache case study.

If the headache is of recent onset, extending over a period of a few days or a few weeks, and is of very severe intensity, then it is problematical that it is of ocular or visual origin, and intracranial lesion should be im-

mediately investigated. If it is a severe chronic headache extending over many years and revealing a lengthy medical history with no apparent etiology being revealed, then there is a very high correlation that this may be ocular migraine.

In any history of the headache of migraine intensity, the patient should be questioned about hereditary possibilities. It is a well established fact that a migraine patient can many times have a parent, grandparent, brother, sister, aunt, or uncle who is also subject to migraine headache. When this has been brought out in the history it is still not an assurance that this patient's migraine would be the classical form known as migraine simplex. It may still be an ocular migraine, as latent binocular dysfunction seemingly can be of a hereditary nature.

#### The Headache Diary

As we have seen from the foregoing discussion, a headache is merely a symptom. We have tried to outline a method for observing that symptom and noting any definite syndrome it may follow. We find, however, that many patients have never entertained the thought of observing their headache characteristics and cannot give accurate information concerning it.

For these people, the headache diary establishes within them a new hope for a scientific

## HEADACHE DIARY

NAME \_\_\_\_\_

### INSTRUCTIONS:

Page \_\_\_\_\_

1. Keep a daily record of the presence or absence of a headache. Record something each day.
2. If no headache all day, write across several columns "No Headache."
3. Record the intensity of the head pain by number. The following table will guide you:

- #1—Very Mild—Slightest possible pain—can be forgotten.
- #2—Mild—Cannot be forgotten but aspirin not necessary.
- #3—Average—Aspirin is necessary and will relieve. Quite an uncomfortable pain.
- #4—Severe—Aspirin will not relieve—very difficult to work.
- #5—Very Severe—Must go to bed—cannot work—Extreme pain.

Date	Time Began	Location	Time Left	Nausea Vomiting	Dizziness	Time Retired Night Before	Intensity	Medications Used	REMARKS

Figure 6

routine which may eventuate in relief. They cooperate with a zeal in outlining each column of the diary and especially in trying to observe any activity which may consistently be associated with the headaches.

As the time involved to solve a case of ocular migraine can extend to a year of trial lenses, re-examinations, trial periods, frame adjustments, etc., this headache diary may prove to be the slim thread of evidence that progress is being made. No one should attempt to become involved in headache therapy unless he is extremely patient and willing to exhaust every available bit of information at his disposal. He should be willing to enlist the support of any and all allied professions which may have some bearing on the case at hand. For this type of trial-and-error procedure there is no better commentary than a well kept diary.

The use of this diary has several advantages in a headache case study:

1. Encouragement to the patient. There is perhaps no more discouraged person in the world than the migraine headache patient who has spent hundreds and even thousands of dollars for medical fees and tests and has had no relief from his gnawing chronic pain. If you attempt in any way to try to help this person, you should be scrupulously careful to inform him that you cannot perform a miracle, that you are going to carefully exhaust every possibility at your command, but you will not guarantee results. When you have carefully explained the possibility of a latent binocular dysfunction by simple demonstration and then have instructed the patient in the use of the diary, he immediately senses that here at least is a gleam of hope. He realizes headache therapy is not hopeless if analyzed scientifically. This confidence which you have gained must be considered a very sacred and solemn trust on your part because if you fail, this person may commit suicide thinking this was his last opportunity for relief. Unless you are willing to accept such a moral obligation, I would heartily suggest that you refer the patient to another optometrist in the area who is doing more of this work.

2. Find out if the headache follows any regular syndrome. The importance of knowing if the symptoms follow a regular pattern has already been discussed. It is mentioned here as some patients have not realized this pattern and the systematic daily record will enlighten both patient and practitioner.

3. Find out if the headache follows any definite activity. If a patient awakens in the morning with a headache and the diary reveals that the evening previous to these headaches there was extensive reading or

near-seeing activity, then sinusitis, hypertension, intracranial lesions, etc., can be more quickly ruled out. Your past experience has shown that fatigue resulting from a refractive anomaly can produce such a syndrome and is a guide as to a beginning therapy.

4. Determine multiple headaches. Many times the use of a diary is the only way to differentiate one kind of headache from another. The patient was aware of only a headache. After keeping the diary, he soon learns he has two or even three kinds of headaches and becomes very cooperative if he feels you can relieve one of them and guide him to the right person for further care.

5. Determine the effect of any change in therapy. By observing the headache syndrome prior to lens application, then observing any alteration in that syndrome following a particular lens change, the practitioner can soon see if progress is being made through vision therapy. Also to be included here, is the effect of any medication which the patient might take during the course of the case study. If some physician is working with the individual at the same time, care must be taken not to confuse the effect of medication with the effect of vision therapy. An important phase of multiple headaches should be mentioned here. If two controls are changed at the same time and relief ensues, then one should be maintained while the other is again omitted. Then the reverse should be tried. If, after both attempts, the headaches are only relieved with both treatments, then they should both remain.

6. May aid allied practitioner to establish a cure. A case comes to mind of a man who was asked to keep a diary of his headaches for a month prior to his appointment. During that month he was suddenly transferred to another state but took the diary with him and kept an accurate record each day. When it was finished he went to an otolaryngologist in that city and showed him the completed record. When the physician studied the syndrome he immediately suspicioned sinusitis, treated him, and subsequently cured the headaches.

This experience emphasizes the fact that any professional person dealing in human suffering has a personal obligation to try to help those who seek his services. If he feels a practitioner in an allied field can better care for the patient's problem, it is his obligation to refer the patient out for care. Since so many people seek the help of the optometrist when they suffer head pains or headache, he becomes a headache consultant and should be conversant with the therapy used in other specialties besides his own.



## Conclusion

Headache, especially migraine, is a symptom which may direct a patient to every branch of the healing arts. Even though it is referred to as a symptom complex, it acts like a disease in that it can produce considerable deviation of health from the normal. Migraine in its typical or classical form is easy to diagnose, but in its atypical forms can be difficult and confusing.

The purpose of this paper is to guide the vision specialist in his case history with the headache patient, to better equip him to be a headache consultant, and to try to establish some order out of the chaos of cephalalgic symptomatology.

*Editor's Note: Reprints of the article "Ocular Migraine and Prolonged Occlusion" by Dr. Raymond Roy (THE OPTOMETRIC WEEKLY, Sept. 3, 1953), are available from the author at 60 cents per copy. Headache diaries and perscription forms also are available from the author at the following rates: 100—\$2.50; 250—\$6; 500—\$11.50; 1000—\$20; all plus postage. Write: Dr. R. R. Roy, 318 S. W. Alder St., Portland 4, Ore.*

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## Elect Officers at Utah Convention

Officers for the coming year were elected at the annual meeting and seminar of the Utah Optometric Association, held April 23, 24 and 25, at the Ben Lomond Hotel, Ogden.

Those newly-elected to serve the association include Dr. R. D. Ostler, Price, president; Dr. Bruce J. Parsons, Murray, first vice-president; Dr. Loyal Seeholzer, Logan, second vice-president; Dr. D. O. Larsen, Richfield, secretary; Dr. Vance E. Burgon, Midvale, treasurer. Immediate past-president of the association is Dr. M. Curtis Dearden, Salt Lake City.

Dr. Allen C. Holland and Dr. Rupert Flower were the featured speakers at the association's educational seminar, held in conjunction with the convention.

In the field of new activities for the association are the newly-organized credit union for UOA members, and the lecture arrangements schedule by which two members of the association attend service club lectures and group lectures, such as P.T.A., etc.

The auxiliary to the Utah Optometric Association also met at the Ben Lomond Hotel, April 23-25. Officers for the auxiliary were elected and include: Mrs. George Harris, Ogden, president; Mrs. Gerald Bagley, Salt Lake City, first vice-president; Mrs. Vance Burgon, Midvale, second vice-president; and Mrs. Loyal Seeholzer, Logan, secretary-treasurer.

## Honor 24 Seniors at PSCO

Twenty-four senior students out of a class of ninety-eight were recently honored at a special assembly held at the Pennsylvania State College of Optometry. The students were awarded certificates of membership in the Honor Society of PSCO, a group made up of students maintaining an average of 87 per cent in all subjects, out of a total possibility of 100 per cent. The faculty sponsor of the society, Dr. Jacob Nevyas, professor of chemistry, presented the awards to the following students:

Stephen Baschak, Allentown; Leon Candeb, Philadelphia; David Ganse, Lancaster; Harry Goldberg, Pittsburgh; Herbert Goldberger, Miami Beach, Florida; Shahane Kirman, Drexel Hill; David Maitin, Philadelphia; Jerome Mattes, Pittsburgh; Clarence Oka, Waiialua, Hawaii; Reno Orsi, Pittsfield; Morton Richman, Philadelphia; Edwin Ross, Mobile, Alabama; Irwin Rubin, Atlantic City, New Jersey; Jerome Schleifer, Atlantic City, New Jersey; William Shearin, Whitakers, North Carolina; Robert Shepard, Miami, Florida; Edward Smith, Manchester, Connecticut; John Stauffer, Bareville; Marvin Stiglitz, Bronx, New York; Joseph Toland, Philadelphia; Albert Tauda, Honolulu, Hawaii; Thomas VanNatta, Lewistown; Norbert Winter, Valencia; and Charles Zandel, Philadelphia.