Case History

The Chief Complaint (CC)

The patient is a 69 year old female with a chief complaint of Migraine Headache. Patient also complains of hypertension and depression. These conditions are influential to the overall diagnosis of the patient because they are noted as underlying hosts to the principal complaint.

History of Present Illness(HPI)

The patient began experiencing migraine headaches after giving birth to her son on March 31,1972. The patient states that she is unaware of any injury or trauma which might have been related or caused headaches. In May of 1972 her Medical Doctor had diagnosed her with Migraine Headache. Headache has a stabbing, consistent nature and is always on her right side. The headaches would not not radiate to any other part of the head. The headache starts usually at 2 am once a month and lasts about 4-8 hours. She reports that she feels the migraine is coming just after being outdoors for a while, for instance walking for 40 min or an hour. In most cases, the patient reports feelings of spots of light prior to the beginning of upcoming headache. The patient reports that the level of the pain is 10 out of 10 on a scale of 1 to 10 (with 1 being relatively no pain, and 10 being severe pain). Nausea and vomiting are always associated symptoms. Patient states that taking Imitrex or Zomig at the very beginning of headache eases the pain in some cases. Sleeping in a dark quiet room for 6-8 hours is usually helpful. Patient stated that she was born in Ukraine and worked as an elementary school teacher.

Migraine Headaches have been so intensive that she has had to call sick and miss days of work. In 1995 she emigrated to USA to live with her son. She continues to suffer from Migraine. Patient is

retired and lives alone in a subsidized apartment. The patient is currently receiving acupuncture treatment, which helped her previously with her other complaint of heel spur.

Past Medical History

The patient had a tonsillectomy and adenoidectomy in 1953. She had a normal vaginal delivery in 1972. She was pregnant for a second time in 1982, but had an abortion due to upcoming divorce and stress. The patient had right shoulder arthroscopy in 2001, endometrial ablations in 2006 and 2009 and polypectomy during colonoscopy in 2011. Also, patient had basal cell carcinoma in her right outer ear And it was removed in 2013. The patient has been diagnosed with benign hypertension.

Medications(MEDS)

The patient is currently taking Propranolol LA 160 mg 1 cap bid, Tramadol 50mg 1 tab q6h prn to manage her migraine and hypertension. She is also on Fosamax 70 mg 1 t qd, Vitamin D3 5000IU 1c qd and Calcium 500mg+D 500mg 2tab qd to prevent bone loss and a risk of osteoporosis. She is taking Citalopram 20mg 1t hs and Alprazolam 0.25 mg 1t hs prescribed by her psychiatrist to manage her depression. Patient is also taking Aspirin 81 mg 1t qd and Coratin (Red Yeast Extract) 600 mg 1cap qd.

Allergies (All/RXNs)

The patient reported no known drug-related allergies or food sensitives.

Social History

The patient lives alone in a subsidized apartment. Her son, his wife and grandchildren live 15 minutes away and visit her regularly. She has a 73 year old boyfriend who lives in the same building as

her. She has many friends and spends her spare time by swimming in a pool twice a week and walking in her neighborhood. She likes knitting. The patient reports that she has never smoked. She occasionally drinks white wine during social occasions. She drinks coffee once a day and green tea 1-2 times a day.

Work History

The patient was working as an elementary school teacher in Ukraine. She immigrated with her parents in 1995 to the USA. She went to college to learn English. Patient worked as a teacher aid/assistant in a preschool setting for a few months. She stated that immigration, her old parents health and lack of language was attributing to her depression and she was not be able to work any longer.

Family History

The patient's father died at the age of 83 with Leukemia. He also suffered with COPD and hypertension. Her mother passed away at the age of 86. The patient reports that her mother had Parkinson's, hypertension and died from stroke. The patient had one stepbrother, who died at the age of 58 from colon cancer. The patient is not aware of any other health concerns about his health.

Gynecological Obstetric History

The patient began her menarche at the age of 13. Additionally, the patient has had 2 pregnancies; 1 live birth, and 1 abortion. Her menopause started when she was 49.

Review of Systems (ROS)

Skin, Hair, Nails: The patient reports that her nails have become more brittle for the past 2 years.

Head and Neck: The patient reports that, at times, she will feel a sharp, stabbing pain inside her head from her right eye. She also sees floaters when she is tired. In August of 2013, the patient was presented in the emergency room with a non-painful ocular migraine where her left peripheral vision was blocked. That instance has not reoccurred since.

Ears, Nose, Mouth, Throat: See *Present Illness.* The patient reports bilateral tinnitus that is high in pitch and worse with Ibuprofen. She tends to have a dry mouth and scratchy throat.

Gastrointestinal: The patient reports recently having heartburn after meals. The patient is having bowel movements three times per day that are easy to pass and well-formed.

Respiratory and Cardiovascular: The patient currently has controlled hypertension. Seeing a MD, approximately 4 times per year. No dyspnea, chest pain or palpitations. EKG is unremarkable. No cough, no wheezing, no SOB.

Musculoskeletal: Mild, aching, low back pain, sometimes radiated down the right leg. Painful right heel due to calcaneal spur.

Urogential: The patient does not report any problems with urination. Her urine is clear, pale yellow, with slight odor.

Peripheral Vascular: Varicose veins appeared in both legs, but predominantly on the right. Patient is wearing light elastic pantyhose prescribed by her MD.

Mental Status: Emotionally, the patient reports being depressed and withdrawn socially due to the pain. She reports that she hates to be always" prepared" for her monthly migraine to come back.

Neurological: The patient has no other neurological complaints, except for migraine and slight forgetfulness.

Temperature: The patient is very sensitive to heat, especially hot summer climate in Chicago.

Appetite.: The patient reports that her appetite is very good but she thinks she doesn't eats too much. She only eats 3 meals a day. Her last meal is not later then 6pm due to her worries to gain weight.

Thirst: The patient does not feel particularly thirsty. She reports to drinking about 5 glasses of water per day.

Sleep: The patient does not have any difficulty with her sleep; however, about 3-4 nights a month,

she will wake up around 3:00 am.

Energy: The patient's energy level is normal.

Physical Exam

Vital Signs: Height (without shoes) 5ft. 4 in, Weight (dressed) 145 lb. BMI 24.9.Blood pressure is 118/78 in patient's left arm when sitting down. HR 56 and regular. Respiratory Rate was not taken.

Skin & Lymph Nodes: Nails are brittle and split at ends. Lunula and eponychium are healthy. Body of nail is ridged. Also, her hair has a medium thick texture. The patient's skin appears cold, slight dry, but color is healthy. Overall skin is combination type. No cervical, axillary, epitrochlear, inguinal lymphadenopathy.

HEENT: The skull is atraumatic. The hair has a thinner texture. Patient is wearing glasses for reading. Sclera white, conjunctiva pink. Pupils are equally round and reactive to light and accommodation. No hemorrhages or exudate. Ears acuity diminished to whispering voice; intact to spoken voice. Ears are without excessive wax. Patient does not have canker sores or signs of infection in the oral cavity. Oral mucosa is dry and slightly red; pharynx without exudate. Patient has multiples dental cavities treated prior. Patient's tongue is midline. Nasal mucosa pink, no sinus tenderness.

Neck: Trachea appears mid-line, neck supple; thyroid isthmus palpable.

Thorax and Lungs: Thorax symmetric. Breath sound vesicular with no added sound.

Cardiovascular: There has been no additional cardiovascular exam performed.

Breast: Symmetric. No masses.

Abdomen: The patient's abdomen is symmetric, with no visible or palpable masses. Abdomen has active bowel sounds. It is soft and non-tender. No costovertibral angle tenderness. There are no bruits sounds in epigastric area. There is a slight discomfort upon palpating epigastric area, but

it is not painful.

Musculoskeletal: No joint deformities. Good ROM in hands, wrists, elbows, shoulders, hips, knees, and ankles. Loose muscle tone. See ROS for heel spur. Pain is 7 out of 10 when palpated medial side of the heel. Gait is stable. Reflexes were not performed during the visit.

Neurologic: Alert and cooperative. Oriented to person, place and time. There were no neurological examinations performed.

Tongue: The patient's tongue is purplish, moist, slightly phlegm on a sides. Her tongue had distended sub-lingual veins. It also had a thin, white, coat.

Pulse: Generally, the patient has a slippery pulse on the right and a moderate wiry pulse on the left. Both Chi positions are weak.

Laboratory results

Patient did not provide any of the lab results, except her latest results of Colonoscopy and Upper GI endoscopy

02/17/16 12:49 PM Procedure: Colonoscopy and Upper GI Endoscopy

Indications: Colon cancer screening in patient at an increased risk: Colorectal cancer in patient's brother at age 57; high risk colon cancer surveillance: Personal history of colonic polyps.

Findings: The retroflexed view of the distal rectum and anal verge was normal and showed no anal or rectal abnormalities. A few small-mouthed diverticula were found in the sigmoid colon in the ascending colon.

The examined esophagus was normal. A few localized small erosions were found in the gastric antrum. There were stigmata of recent bleeding. Biopsies were taken with a cold forceps for histology. A mild post-ulcer deformity was found in the duodenal bulb. A few erosion were found in the duodenal bulb.

Recommendation: Await pathology results. High fiber diet.

Assessment

Traditional East Asian Medicine (TEAM) Disease Category

The patient's case falls into the disease category of 头痛 (Tou Tong), Headache, pain in the head. According to "Chinese Medical Characters 4: Diagnostic Vocabulary, 痛 was extended to mean" pain". The character for head is 头 (Tou).

Migraine 偏头痛 (Pian Tou Tong) is one is subcategories of Headache 头痛(Tou Tong). 偏 Pian means inclined to one side, partial. The patient's case is a right sided headache.

TCM Diagnosis

The TCM diagnosis for this case is Liver-Yang rising headache, Qi and Blood stagnation in the ShaoYang channel.

TEAM Differential Channel Diagnosis

There are two possible differential channel diagnosis for this case; one being the main ShaoYang channel and the other occasional TaiYang channel.

For this particular case, temporal headache is distributed on a ShaoYang channel and often concentrates behind the eye. The only relief patient gets is by closing her eyes and sleeping in a dark room. In addition, her distended, purple varicose veins are mainly distributed on the lateral side of the right leg. That is why the main differential channel diagnosis is ShaoYang channel headache.

It is also possible that the TaiYang channel of the foot is involved in this case, since patient headaches occasionally starts after being exposed to a wind while walking in a neighborhood. The wind penetrates into the TaiYang channel, constricting and obstructing circulation of qi and blood, resulting

in pain. In this case, the Urinary Bladder channel is an opening channel for Wind evil to enter the body through the Tianzhu UB 10 天柱(Celestial Pillar) and Feng Chi GB 20 风池 (Wind pool). According to Andrew Ellis, Nigel Wiseman and Ken Boss, “Wind pathogens are said to collect in this depression. Thus it is known as Wind Pool” (1989, p.52). UB16 and GB20 both share its neighboring location in the back of the head.

TEAM Differential Pattern Diagnosis

There are numerous differential patterns 辩证 in TEAM that can cause headache. According to Will Maclean and Jane Lyttleton, among these patterns are External invasion, Liver Qi constraint; Liver Fire; Ascendant Liver Yang and wind, with Yin deficiency, Cold affecting the Liver and Stomach, phlegm damp, blood stasis, stomach heat, stomach and gallbladder disharmony, Qi deficiency, blood deficiency, kidney deficiency (2007).

External pathogens, wind cold, wind heat, wind damp, summer-heat, either singly or in combination might be a possible provocative cause for headache due to patient's headaches occasionally occurring right after being outside. In this particular case, if patient headache started while being outside, the primary channel involved for this pattern would be TaiYang of the Foot. External pathogen will then move straight to ShaoYang channel when it resides in the period of migraine headache. Patient reported right sided temporal headaches resided in one location, located on the right ShaoYang channel of the foot. There is a possibility that wind travels to ShaoYang channel through occipital lobe of the head of TaiYang. The areas that she feels pain are fixed locations. Patient doesn't feel any signs of being cold or hot, so wind-cold or wind-heat, or summer-heat are not a valid diagnosis for the patient. However, all headaches from external invasion are acute and associated with exposure to a sudden change of weather oe an external pathogen. So wind could be a provocative cause for this type of headache.

Qi and blood vacuity are being rulled out of the possible diagnosis for this case. The patient would present a pale complexion, fatigue, spontaneous sweating, and a fine, thin weak pulse (Sionneau and Gang, 1998). The headache would be dull, aching pain that is worse with exertion. Her Chi positions are weak , so Kidney vacuity is present.

The patient has slippery pulse on the right and a moderately wiry pulse on the left. The pulse was taken at the time when patient didn't experience any pain or signs of discomfort. That confirms that the pulse represents general characteristics of the patient health and not necessarily a reflection of characteristics of her differentiation diagnosis.

Patient tongue is purplish, slightly phlegmy on the sides with thin white coat. The tongue had distended sub-lingual veins. Patient reported that her cholesterol level has been elevated. Hyperlipidemia is the accumulation of abnormally high levels of fat(cholesterol, triglycerides, or both) in the blood. According to Traditional Chinese Medicine elevated cholesterol is diagnosed as the accumulation of damp and phlegm in the blood vessels. Considering patient pre-existing condition and unilateral stabbing character of the pain, a combination of patterns of Ascending Liver Yang, with yin deficiency, Blood stasis and Damp-Phlegm in Luo collaterals are considered for this particular case.

Etiology and Pathomechanism

Xue and Qi deficiency at postpartum lead to an easy invasion of Liver wind, which stayed and then lead to an obstruction of Qi and Xue in the channels. Continuous stagnation of liver channel and involvement of cold property medicine lead to Qi and Blood stagnation in the ShaoYang channel (right sided headache, right shoulder arthroscopy). Disruption of movement of Qi in the Stomach channel(nausea and vomiting) lead to chronic heartburn.

Chronic headaches involving blood stasis patterns have a long history of constrained Liver Qi which in this case could started after Qi and Blood loss at delivery of her son and emotional components of divorce and stressful job.

Discussion of the Chief Complaint in the Classics

Patient delivered a baby on March, 31, 1972. The delivery was normal, without the use of an epidural. The patient remembers being exhausted and deficient. She stated that her migraine headaches started at that time. In Huang Di Nei Jing Su Wen(HDNJ) Chapter 2 (Unshuld, Chapter 2, 2011, p.54),

" If one acts contrary to the qi of spring, then

the minor yang not promote generation.

The liver Qi changes internally."

Chapter 3 of HDNJ (Unshuld, Chapter 3, 2011, p. 78)

"Hence,

if one was harmed in spring by wind,

[the evil qi stays for long]".

This passage talked about the digestive system, but I think it can be applied to Liver Wind evil that stayed for a long time and cause chronic headaches.

"Wind is the origin of the one hundred diseases", HDNJ Chapter 3 (Unshuld, Chapter 3, 2011, p.72). Wind-evil, a yang pathogen, has a nature to invade upper part of the body. When the patient's Qi and Blood are robust wind can not make an entrance or harass the interior. In this case patient experienced headache at postpartum when the body was exhausted and deficient.

"Hence, as for the qi of spring, [it causes] diseases in the head.", HDNJ Chapter 4 (Unshuld, Chapter 4, 2011, p. 85).

According to HDNJ Chapter 3 (Unshuld, Chapter 3, 2011, p. 74),

"When the yang does not dominate its yin,

then the Qi of the five depots enter into a struggle.

The nine orifices are impassible."

Unschuld illustrates this passage to show that pathological changes cause heat and movement in abundance of yang. Most importantantly to note is that patient's unilateral headaches could be explained as unilateral dominance of Yin Qi, which causes stand-still and blockages.

According to HDNJ Chapter 3, (Unshuld, Chapter 3, 2011, p. 76),

> "When wind settles [in the body] and encroaches upon the [proper] Qi,
> then the essence vanishes,
> and the evil harms the liver".

Interior Wind is the origin of disharmony in the Liver. Liver is Wood and can easily generate Fire. Excessive Heat can harm Yin/Essence/Blood.

Chapter 4 Su Wen, Discourse on the True Words in The Golden Cabinet,(Unshuld, Chapter 4, 2011) has a dialog about eight winds and five winds. The eight Winds from eight directions bringing forth evil Qi and transforming to five winds and damaging organs.

> "Hence,
> those who are experts in treatment,
> they treat[a disease as long as it is in] the skin and the body hair
> …
> Next are those who treat[a disease when it is in] the sinews and vessels.", HDNJ Chapter 5 (Unshuld, Chapter 5, 2011, p. 119). Patient's MD certainly missed an opportunity to treat headache at the very beginning stage. Patient has been suffering from recurring Migraine for 44 years. Patient is prescribed a Propranolol, a beta blocker. Beta-blockers affect the heart and circulation (blood flow through arteries and veins). The factors that may be involved in contributing to the anti-hypertensive action include: decreased cardiac output, inhibition of renin release by the kidneys, and diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. The physician is attacking a disease at this stage.

Patient's chief complain is a right-sided headache. The acupuncture treatment strategy should concentrate on choosing points of the left side. HDNJ Chapter 5, (Unshuld, Chapter 5, 2011, p. 120),

> "Hence,
>
> those who know well how to use the needles,
>
> …
>
> With the right they treat left..."

Also, the decision was made to treat patient preventively during the remission stage, not while Migraine is in the full forth. HDNJ Chapter 5, (Unshuld, Chapter 5, 2011, p. 122) states not to needle while evil is strong, but rather until it weakens.

> "Hence it is said:
>
> When the disease begins to emerge, one can pierce and [the disease]ends.
>
> When it abounds, one must wait until it weakens and [the disease, when
>
> pierced,]ends.
>
> Hence,
>
> after it has become light, scatter it."

Biomedical Differential Diagnosis

Patient was diagnosed with Migraine Headache in May 1972.

According to Merck manual, Migraine is falling into Neurological disorder section category. Migraine is an episodic primary headache disorder characterized by recurrent disabling attacks of moderate to severe headache. The associated symptoms are gastrointestinal(e.g., nausea, emesis), autonomic(pallor, flushing, increased urination), and increased sensitivity to environmental stimuli(e.g., light, sound). Migraine classification includes cases with and without aura preceding the actual attack. These reversible focal neurological symptoms may start 20-60 min prior to Migraine. The visual symptoms include spots with light, zigzag lines, scotomas or regions of visual loss. The other non-visual

symptoms might include tingling and numbness and/or language impairment.

According to Stewart WF:" The median age of onset of migraine is approximately 20-25 for females. The patient onset falls into these criteria of incidence.

According to E. Dilli and D.W.Dodick outline of diagnostic criteria for migraine aura patient has to have at least 2 attacks fulfilling certain criteria. Patient has fully reversible visual (spots of light) and sensory (intolerance of noise) symptoms, but no motor weakness. Patient has two of the following: unilateral (right sided) headache including positive and/or negative features, visual symptoms following by sensory symptoms develops gradually. Patient's Migraine is not attributed or caused by any other disorder. I agree with the physician's assessment and current diagnosis of Classical Migraine. The correct and more precise diagnosis would be Classical Migraine with aura if we would have a complete physician medical record. However, we have information only according to the patient statement.

Patient also presented with occasional (more then once a week) symptoms of heartburn and acid reflex. It is aggravated by foods such as red wine, chocolate, keffir, citrus fruits, coffee, and onions. Patient was diagnosed with GERD after recent Upper GI endoscopy. Patients over 55 years old usually warrant endoscopy to detect *esophagitis*, peptic strictures, or *Barrett's esophagus*. Biopsy was taken for histology because of a current finding of a few localized small erosion in the gastric antrum and stigmata of recent bleeding. A mild post-ulcer deformity was found in the duodenal bulb. A few erosions were found in the duodenal bulb. Patient results came with negative for H. pylori. Approximately 50% of patients with GERD will have no disease on endoscopy. JAMA 2006;295:1566-1576.

Patient was prescribed Ranitidine 150 mg 1t Bid with 11 refills. Ranitidine is in a class of medications called H2 blockers. It decreases the amount of acid made in the stomach. Ranitidine is also used sometimes to treat upper gastrointestinal bleeding and to prevent stress ulcers, stomach damage from

use of nonsteroidal anti-inflammatory drugs (NSAIDs), and aspiration of stomach acid during anesthesia. According to MedlinePlus, Ranitidine should be taken for no longer then 2 weeks, unless prescribed by the doctor for longer. It also advised to continue with the same diet regimen. Patient is given 11 refills with no specific diet regimen change.

According to WebMD, Gastroesophageal reflux disease, or GERD, is a digestive disorder that affects the lower esophageal sphincter (LES), the ring of muscle between the esophagus and stomach. In most cases, GERD can be relieved through diet and lifestyle changes; however, some people may require medication or surgery. I assume that a history of prolonged taking of Aspirin, nausea symptoms associated with migraine attacks, psychoemotional events could contribute to her current heartburn symptoms and recent Upper GI endoscopy results. I disagree with the MD on completely ignoring nutritional and dietary evaluation and prompt referral to a specialist (nutritionist, dietitian, TCM practitioner) to simply support and prevent further damage to esophageal lining and progression of the disease. I also disagree on giving 11 refills of Ranitidine to a patient without monitoring patient condition.

Evidence Based Treatment:

Approximately 4% of adults experience headaches nearly every day. Migraine and tension-type headaches are common headache disorders in clinic and result in significant reduction in social activities and work capacity of the suffers (Woolhouse, 2005).

and other types of headaches cause significant productive loss to employers. They are also one of the most common complaints seen in the doctor's office. Although drug treatments are very effective, patients suffering from Migraine attacks often use a wide spectrum of complementary, as well as alternative treatments. Chronic stress may contribute to the development of the most common types of headaches, which are Migraine and tension-type. Therefore, alternative treatments aim at stress reduction. These treatments include acupuncture, massage, herbs, and relaxation. Many clinical studies

have been conducted to consider these alternative therapies as effective treatments for some patients with headaches.

According to the National Institute of Health, bio-medicine holds numerous approaches to treating Chronic Migraine. These treatments include the use of non-steroidal anti-inflammatory drugs (NSAIDs), analgesic medication, deep breathing exercises, yoga, and nerve block injection. While there have been research studies associating acupuncture to Chronic Migraine distinctively, there are extensive studies validating the effectiveness of acupuncture for pain, frequency, and duration of the Migraine attacks. According to a case series demonstrating the treatment of Migraine headache in two middle-aged female patients with multi-year symptoms in the Journal of Chinese Medicine, duration and intensity of the Migraine headaches decreased in both patients within the first week of treatment and were resolved by the third month. The first patient reported Migraines occurring one to two times per week, lasting for up to ten hours, with a severe stabbing pain rated at eight to ten on a scale of one to ten, and nausea. One week after the initial treatment, the patient reported having no migraines during the previous week. This patient's second acupuncture treatment also included taking prescribed herbal formula, and reported no migraines by the end of the second week. The second patient reported Migraine episodes lasting three to four months during which the migraines occurred daily, normally beginning in the morning and lasting approximately four to five hours. This patient reported a significant decrease in Migraine symptoms following her first treatment. By the second week, headache frequency had decreased by 50 percent, headache duration had decreased by 40 percent, and headache intensity had decreased by nearly 75 percent (Allen, Deng and Langland, 2016). This case series illustrated the successful treatment of Chronic Migraines that were unresolved following traditional interventions. Additionally, this case series supports the use of acupuncture and herbal supplement as an alternative for the treatment of Chronic Migraine.

As stated previously, the National Institute of Health suggests the practice of yoga as a biomedical approach to the treatment of Chronic Migraine. Yoga is a relaxation technique whose goal aims to produce the body's natural relaxation response, characterized by slower respiratory rate, lower blood pressure, and an increased feeling of well-being. Yoga has been studied to assess whether it

might be of value in managing various health conditions. More specifically, Advanced Biomedical Research conducted a case study on the effects of 12 week yoga training on headache frequency, severity, and duration of female migraine' episodes. 32 patients were divided into two groups; the control group received only medication for 12 weeks, and the yoga group was placed in a yoga training program that consisted of 3 sessions per week in additional to the same medical treatment. When comparing results from the yoga and control group after 12 weeks, the yoga group showed a greater reduction in headache severity, frequency, and headache impact on the patients' lives. However, changes in the control group were not significant (Boroujeni and Marandi, 2015). Although the reduction of duration of headache was not found to be significant in this research study, yoga was beneficial on various migraine parameters, including frequency and intensity of the episodes. This research study depicted that yoga released tensions accumulated around the areas of pain, as well as loosen tight muscles, which can trigger headaches. Therefore, yoga can potentially assist migraine episodes.

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