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Applied Kinesiology management of migraine with aura

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Objective: To explain the application of Applied Kinesiology in the management of a 22-year-old female patient experiencing chronic Severe Migraine with aura.

Clinical features: The patient presented with Chronic Migraine with aura of eleven months.

Intervention & Outcome: Examination and treatment utilising Applied Kinesiology methods was successful with complete resolution of all patient Symptomatology.

Conclusion: Management of a case of migraine with aura in a 22-year-old female utilising Applied Kinesiology methods is presented. It should be noted that correction was obtained by utilising an injury recall technique involving assisting the brain in communicating with injured parts of the body, correction of cranial faults to restore proper movement and nerve function, and utilisation of manganese minerals aiding in supporting joint alignment for chiropractic manipulation and strengthening joint integrity.

After corrections were accomplished, all postural deviations and muscle imbalances were quickly normalised as well as chief complaint symptoms by the patient. Cause of migraines are known to be varied, however, utilising Applied Kinesiology permits practitioners to go beyond treating symptoms only in hopes of correcting root cause imbalances.

Indexing terms: Chiropractic; Applied Kinesiology; migraine; aura; root cause imbalance.

Introduction

Migraine with aura (also called classic migraine) is a recurring severe headache that strikes after or at the same time as sensory disturbances called aura. Most people who suffer from migraine with aura report temporary visual symptoms. Common visual complaints include flashes of light, blind spots (scotomas), zig-zag lines crossing the field of vision, flashes of light, or even loss of vision.

Other temporary disturbances associated with migraine aura may include muscle weakness, speech difficulty, dizziness, ear ringing, or numbness typically felt in a hand or one side of the face. People who are affected by

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migraine with aura are at a mildly increased risk of stroke.

Medical treatment is aimed at relieving migraine pain. Types of medication that is often prescribed include pain relievers, triptans, calcitonin gene-related peptide (CGRP) antagonists, anti-nausea drugs, Botox injections, blood pressure lowering medications, antidepressants, or opioid drugs. (1)

The patient

A 22-year-old female patient presented with chronic migraine with aura of 11 months complaining of pain frequency at '*almost a daily rate*'. She rates the migraine pain intensity at 7-8/10 pain level, with 10 being the worst. She says about once or twice each month her migraines intensify to a 10+/10 pain level where she '*doesn't want to go on with life anymore*'.

Her condition began about a year ago following a pick-up volleyball game in which the ball was spiked into the side of her right temple area as she was attempting to make a block at the net. She had never experienced severe headaches prior, but does mention having an occasional once or twice a year mild headache from '*complete lack of sleep*'. She had advanced imaging performed of cervical spine radiographs and MRI of the head. Both tests resulted negative.

Symptomatology of her chief complaint worsens when she experiences fatigue from sleep deprivation, excessive stress, exercising too vigorously, poor eating choices, and occasionally when the weather changes drastically. She has tried over-the-counter pain and inflammation medication, anti-depressant prescription medication per her primary medical doctor, massage, and acupuncture. Anti-depressant medication was recommended because of the drastically declining emotional state she was experiencing due to her long suffering without substantial resolution. She says the only relief she obtains is by laying down in a dark room and attempting to rest for several hours after onset. Pain typically lessens between one to three hours while resting in this manner. She also takes over-the-counter Advil medication, as needed, at high doses of 600-800 mg when resting provides limited relief.

- Health & Family History revealed healthy eating habits of avoiding fast food restaurants, fried foods, soft drinks, alcohol, and candy. She only drinks water and occasional sweet tea. She exercises by light walking for thirty minutes, four times weekly. Her parents are in overall good health with no reported migraine history, heart problems, or other immune challenge. She is a non-smoker.
- Physical examination revealed the following: weight 132 lbs, 60kg; height 5'7", 17mcm; blood pressure supine 110/70, standing 102/68; pulse 70; and salivary pH 7.0.
- Postural evaluation revealed elevated left occiput with left head rotation, elevated right shoulder, anterior head carriage, and level iliac crests.
- Neurological testing of the eyes in circular patterns performed both directions was conducted and found to neurologically impact a previously tested strong muscle by inhibiting it. This positive result is termed ocular lock and is a form of neurological disorganisation. (4)
- Initial muscle palpation revealed extreme diffuse tenderness to right temporal bone, severe local tenderness to right *suboccipital*, moderate diffuse pain to right neck extensors, and moderate pain with correlating taut/tender muscle fibres of the upper region of the *trapezius*.
- Manual muscle testing revealed inhibited neck flexors bilaterally, inhibited right *upper trapezius*, right *triceps*, right *deltoid*, and right wrist flexors.

- Joint challenge mechanisms revealed subluxations at right occiput, Category II (right posterior ischium), T2 (left spinous rotation), and right sphenobasilar fault (forced inspiration assist).
- Injury recall technique (IRT) was initially performed to the right temporal bone due to history of patient's condition and trauma to the area. (4) Corrections of subluxations were then performed.

The patient returned for a following visit 10 days later and reported she had experienced her first relief of more than three consecutive days of no migraine occurrences in over a year. She conveyed she felt improved emotionally as she felt 'hope' for the first time since her migraines commenced. She reported since the time of her initial visit, she experienced only three days of migraines, and were graded with substantially less intensity than before at a 3-4/10 pain level.

She also reported the duration was greatly reduced from lasting one to three hours each occurrence to currently lasting no longer than thirty minutes.

Examination using AK methods was again performed revealing the following: normalisation of right *deltoid* muscle, right *triceps*, right wrist flexors, and bilateral neck flexors; occiput levelled out; subluxations of T2 and right category II posterior ischium remained. Ocular lock also was visualised and remained positive. Further, right *trapezius* continued to show muscle weakness upon manual testing and right sphenobasilar fault was again present.

Ragland's blood pressure test improved 112/72 sitting to 112/74 standing.

Upon re-examination, right temporal bulge was found along with left parietal fault, sacral inspiration fault, and cruciate suture jamming. (4) A ligament stretch test was then performed assessing ligament integrity for potential need of nutritional support assisting joint strengthening. (4) Numerous areas were utilised for evaluation including bilateral wrist and ankle joints. The test displayed that a prior normal functioning indicator muscle became inhibited on each instance any wrist or ankle joint was tested. It was determined that oral insalivation of the mineral manganese negated the ligament stretch test and improved range of motion of the hamstring visualised from a standing stretch position. (2)

Correction of subluxations were accomplished and the patient was sent home.

The patient returned in 2 weeks, and reported zero migraines during the entire duration since her previous visit. She stated she feels '*happy and ready for life again*'. She also noted sleeping throughout the night had greatly improved and her ability for breath inhalations seemed easier, which she had not noticed until recently. Reexamination revealed negative cranial and sacral faults, negative ocular lock, normalised *deltoid* muscle, and negative pain upon deep palpation for all muscle areas involved.

Challenge mechanism revealed T4 (anterior) and T10 (left spinous rotation) subluxations. These areas were then corrected.

The patient was recommended to return in 1 month and continue supplementing manganese at one tablet two times daily for 10 additional weeks. After which, she was advised to consume a whole-food grade multi-mineral containing manganese daily.

Results

The patient returned five months later due to an injury of low back from rigorous exercising. She was questioned about her prior migraines and replied not having experienced one migraine episode or even having one mild headache since her last visit.

Conclusion

Management of a case of migraine with aura in a 22-year-old female utilising Applied Kinesiology methods is presented. It should be noted that correction was obtained by utilising an injury recall technique involving assisting the brain in communicating with injured parts of the body, correction of cranial faults to restore proper movement and nerve function, and utilisation of manganese minerals aiding in supporting joint alignment for chiropractic manipulation and strengthening joint integrity. (4)

After corrections were accomplished, all postural deviations and muscle imbalances were quickly normalised as well as chief complaint symptoms by the patient. Causes of migraines are known to be varied, however, utilising Applied Kinesiology permits practitioners to go beyond treating symptoms only in hopes of correcting root cause imbalances.

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