Sphenopalatine Ganglion Block in Primary Headaches: An American Headache Society Member Survey

**Background** The sphenopalatine ganglion (SPG), in the pterygopalatine fossa, is a known current and historical target for therapeutic intervention in headache disorders because of its role in cranial autonemics and vasodilation. There remains an overall lack of well-established SPG treatment protocols, particularly with the advent of newer commercial devices.

**Methods** A 22 multiple-choice question survey was created to evaluate clinical practice patterns with SPG block and sent to members of the American Headache Society (AHS). Questions focused on determining indications, preferred applicators, medications applied, perceived efficacy, tolerability, and reimbursement.

**Results** One hundred seventy-two of 1,346 (12.8%) AHS members participated. Ninety-three respondents (56.3%) had performed SPG blocks on 50 or fewer patients. The SphenoCath (42.4%) and the T x 360 (41.8%) were the most common methods of application. Ease of use was the top reason for provider preference in applicator type. SPG blocks were mostly used as an as-needed one-time procedure. When a scheduled protocol was used, twice weekly for 6 weeks was most common. Chronic migraine was the most commonly treated headache disorder and rated the most likely to respond to SPG block. Experienced clinicians found SPG more helpful as a stand-alone treatment and tended to report that acute relief was not predictive of enduring response.

**Conclusions** The variety of responses strongly suggests that clinicians would benefit from formalized protocols for SPG blocks. More experienced clinicians may have developed individualized protocols that they feel are more effective. The lack of evidence-based protocols contributes to clinicians not performing SPG blocks more frequently.

Cautionary Notes on Diagnosing Functional Neurologic Disorder as a Neurologist-In-Training

Functional neurologic disorder (FND), although neglected for much of the 20th century, is among the most common conditions encountered by neurologists across clinical settings. High prevalence rates and limited provider expertise in FND have created a considerable need to develop educational initiatives and practical suggestions to guide neurologists in training working with this population. To help avoid diagnostic errors, trainees should keep in mind that (1) marginally positive functional examination signs have low specificity, (2) FND can coexist with other neurologic comorbidities, and (3) bizarre, not previously encountered, neurologic presentations should not be mistakenly diagnosed as FND. Furthermore, trainees should be encouraged to longitudinally follow in their clinics a subset of patients with FND to develop the interview, diagnostic, and neuropsychiatric skills needed to effectively care for this population. As the landscape of neurologic care evolves, neurologists with expertise in FND should advise on shaping elements of the educational curriculum for neurology residents.