

A HUNDRED YEARS AGO

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MIGRAINE AND ITS TREATMENT

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The more characteristic attacks of migraine, in which, after certain prodromata, unilateral headache sets in associated with nausea and vomiting, visual phenomena, sensory symptoms, and vasomotor or secretory disturbance, can rarely be mistaken; but many of these characteristic features are absent, either constantly or in the majority of the attacks. In such cases the nature of the headache is often not recognized. I recently met an instructive instance of this:

A medical man, 42 years of age, consulted me. From about six years of age, he had suffered periodically from headaches which, as he grew older, had become more frequent but less severe. In boyhood, they occurred every three or four months; but now he is liable to an attack every three weeks. The attacks in early life knocked him over completely for two or three days; now, he has generally recovered within twenty-four hours.

Each attack begins with a feeling of discomfort, increasing gradually to a dull, aching pain which becomes more and more severe. It almost invariably commences in the forehead, and is bilateral from its onset, but spreads all over his head as it becomes more severe.

Associated with the headache, there is considerable nausea and an absolute aversion to food; if he attempts to take any he vomits immediately. Any worry, overwork, or emotion may bring on an attack, or aggravate it when present. Generally he has to lie up during an attack, and keeps as quiet and undisturbed as possible. Each attack passes off as suddenly as it came on, and he is soon quite fit again. He often complains of an irritable heart, palpitation and shortness of breath after the severe attacks. These recurring headaches were so disturbing to his professional work that he had to retire from practice a few years ago.

He has had no visual phenomena, such as occur in migraine and he had been treated for gastric disturbances, for his “liver,” and several other “causes” by the numerous physicians whom he had consulted.

Undoubtedly, this was a case of migraine; the periodicity of the attacks, occurrence of nausea, vomiting, and aversion to food; the depression and prostration during the attack; and the general independence of the attacks to external causes make this diagnosis almost certain. Further, on questioning him, I learned that though visual disturbances are almost always absent, on a few occasions he has noticed what he describes as “lines in the air,” immediately preceding the onset of the headache. Finally, his father suffered with similar headaches which ceased towards middle life, and heredity is an important feature of migraine.

The class of migraine is often mistaken or overlooked, more especially in England, where attention has strongly been focussed on collateral disturbances or on its special features. The most remarkable of these are the visual symptoms, and their frequency depends, of course, on the types of case included in migraine. They are present in 62% of cases according to Liveing, 10 per cent according to Moebius, or 12% according to Flatau. Many textbooks too lay undue emphasis on one-sided headache, but experience shows that even in cases in which the pain is usually unilateral it is not constantly so, and a diffuse and general headache may be associated with other characteristic symptoms of migraine.

Migraine should be diagnosed on the characteristic association of a group of features, all of which may be not constantly present, or may be variable in prominence. These symptoms are the paroxysmal or periodic

headaches, often with a history of direct heredity or other neuroses in the family; the association of nausea and vomiting, which come on with the headache or do not precede it for long, as might be expected if gastric disturbances were its cause; the physical and mental prostration during the attacks; and the occasional occurrence of visual phenomena, disturbances of sensation, or of speech.

General measures

Attacks are generally more frequent and more severe when the sufferer is overworked, tired out, or run down. The subject of migraine should work, when possible, in well-ventilated rooms. Regular outdoor exercise and plenty of fresh air are always indicated, and uniformly early hours of sleep are advisable. A carefully arranged diet may be an important factor in modifying the frequency and severity of the attacks. The so-called purin-free diet – i.e., avoiding fish, flesh, and legumes as well as tea and coffee – has been recommended, but such drastic measures should only be tried in exceptionally severe cases as they frequently fail. On the other hand, most patients may with profit avoid excess of meat in their diet, and many seem to improve after adopting this course alone.

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Almost all the subjects of migraine learn that alcohol, especially in spirits, is harmful as is tobacco; probably nothing is more likely to bring on an attack than a visit to a music hall or a smoking concert, possibly owing to the smoke-laden atmosphere and the custom of taking spirit.

Drug treatment

Various drugs have been used to check the attacks, and for this purpose there is nothing equal to the bromides. Charcot recommended large doses over long periods, but I have obtained the best results from doses of 10-15 grains twice or three times a day. Arsenic is effective in certain cases, and tincture of aconite is frequently prescribed.

In women, in whom the majority of the attacks of migraine coincide with the menstrual periods, it is advisable to give larger doses of bromides when the menses are expected.

The treatment of the attacks themselves is of less importance; in certain patients, they can be cut short or aborted by some of the coal tar preparations, especially phenacetin or pyramidon, but many patients prefer to allow the attacks to take their course, and merely seek rest and quiet.

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