

Peculiarities in Migraine – Are they all in the mind for the patient or the doctor?

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Migraine classification is the remit of the International Headache Society (IHS) and their most recent recommendations are contained in the International Classification of Headache Disorders (ICHD-3)¹. These recommendations have been incorporated into the World Health Organization's International Classification of Diseases (ICD-11)¹ which was published in summer 2018.

In addition to the main classification of migraine, the ICHD-3 includes an appendix which contains a number of additional migraine subtypes and associated variants. The appendix is used to present research criteria for a number of novel entities that have not been sufficiently validated by research conducted so far. It is anticipated that some disorders now in the appendix will move into the main body of classification at the next revision.

Is it in the patient's mind?

Pure menstrual migraine or menstrually related migraine are also included in the appendix. Migraine is most common in women between 15-49 years of age who are typically menstruating. It is generally accepted that it is changing hormones that a woman has on a monthly basis which can trigger migraine pathophysiology. However, this migraine pattern may evolve over a woman's reproductive lifetime.

As shown in figure 1, oestrogen levels rise mid-cycle at ovulation, usually at day 14 and then reduce slightly, but remain relatively static until the 2-3 days before menstruation. It is not an absolute fall, but a relative decrease in oestrogen. Menstrual migraine attacks are mostly without aura². In some cases, female patients may also develop migraine at ovulation on a regular basis. In this scenario, a woman may be sensitive to the small drop in oestrogen that occurs, about 12 days before menstruation starts.

Oestrogen levels in Menstrual Cycle:

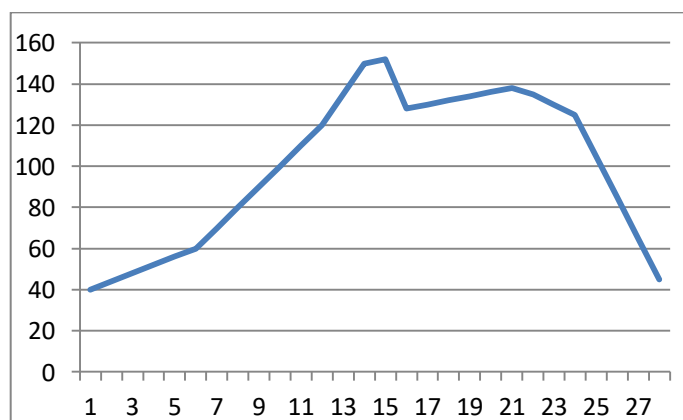


Figure 1 shows how Oestrogen levels vary during the menstrual cycle.

These results are based on a woman having a 28 day menstrual cycle

Pure menstrual migraine is present in 7-14% of migraineurs³ and its occurrence is wholly confined to a strict period around menstruation, and very rarely at other times. It is important that diary-documented evidence, over a minimum of three cycles, is present to confirm the diagnosis of

Pure Menstrual Migraine.

The progesterone only pill (POP) is safe to prescribe in all women with migraine (including those with aura). Desogestrel (POP), reliably, suppresses ovulation and is particularly helpful in those women with pure menstrual migraine. The progesterone contraceptive injection and implant are also effective. The MIRENA coil does not reliably suppress ovulation. Another approach would be to take the oral combined contraceptive pill for 63 to 126 days without the usual break every 21 days.

Migraine subtypes and variants:

A1.1 Migraine without aura

- A1.1.1 Pure menstrual migraine without aura
- A1.1.2 Menstrually related migraine without aura
- A1.1.3 Non-menstrual migraine without aura

A1.4 Complications of migraine

- A1.4.5 Migraine aura status
- A1.4.6 Visual snow

A1.6 Episodic syndromes that may be associated with migraine

- A1.6.4 Infantile colic
- A1.6.5 Alternating hemiplegia of childhood
- A1.6.6 Vestibular migraine

Table 1: ICHD-3 international classification from the appendix

Visual snow is one of these novel entities which is classified in the appendix. It is dynamic, continuous, tiny dots across the entire visual field, persisting for greater than 3 months with Additional visual symptoms of at least two of the following four types: palinopsia, enhanced entoptic phenomena photophobia, impaired night vision (nyctalopia). It is hypothesized that cortical hyperexcitability plays a role in both. As you can see from table 1, it is now considered as a complication of migraine.

It might also be worth asking a person who present with migraine if their children are colicky. Currently, it is thought some of the colicky children are in fact suffering from migraine.

Is it in the Dr's mind?

Many migraine sufferers were misdiagnosed as tension type headaches⁵. It has been reported that the headache in TTH can sometimes be associated with scalp tenderness or allodynia. However, this is a well-recognised feature in migraine patients, again raising the possibility that most of these patients actually have migraine. Further since 2014, chronic migraine has been defined in the International classification of headaches as having headache on 15 days or more per month, of which 8 days/month are headaches which fulfill the criteria for migraine¹. On other days the headache may have features of tension headache. It is therefore important to take an accurate history from those with headache and in particular to ask them if they have two different types of headache.

It has long been established that many patients who are diagnosed as having sinus headaches have got migraine. Sinusitis may activate the cranial autonomic symptoms which are also seen in migraine. This demonstrates how important it is to keep the diagnostic criteria for migraine in mind when assessing people with headaches.

Migraine specialists tend to see many people who have been diagnosed previously with:

Headache due to refractive error – which is rare in adults but may occur in children

Headache attributed to hypertension – chronic arterial hypertension below 180/110mmhg does not appear to cause headaches

1. Cervicogenic headache
2. Trigeminal neuralgia
3. Occipital neuralgia

It is the considered opinion of headache specialists that the above are over diagnosed by doctors. Chronic daily headache is yet another inappropriate diagnosis, it is a descriptive term.

So, the next time you a person with a bad headache, have a little more empathy and maybe like a detective, you can diagnosis it accurately which will help steer your treatment in the right direction.