CHAPTER SIXTEEN

Migraine

Migraine is a disease of periodic headaches separated by intervals of wellness. That is the briefest and possibly the best definition we have for the disease. There are, of course, more elaborate diagnostic criteria for migraine. The location, duration, and character of the pain, and the variety of accompaniments that attend the painful interval allow us, at least in typical cases, to make a diagnosis of migraine with relative ease. In clinical medicine, however, most patients are not typical, and the distinction between migraine and other forms of headache can be quite difficult. Some of the difficulty is of our own making. In our efforts to define migraine on the basis of its painful characteristics, we overlook the cardinal feature of the disease, that it goes away, and between attacks the patient is quite well.

The typical migraine attack, formerly called classic migraine, but now migraine with aura (more descriptive, but it does lack flair) begins with a prodromal or aural experience. This is usually a change in mood or temperament, often a sense of restlessness or despondency. The senses of taste and smell may be disordered during the migraine prodrome, but it is vision that is most often disturbed. The migraine aura may consist of scintillations, sparkling lights across the field of gaze. A blind spot, typically geometric and polyangular in configuration, may appear. This scotoma, frequently bordered by scintillations, may remain fixed in visual space, but more often it expands in size and migrates from one segment of the visual field to another, crossing left-right boundaries. Visual field defects may occur. This is the effect of a drape moving across one half of the vision producing a hemianopia. Sometimes only a quarter of vision is lost, a quadrantanopsia. Curiously, the visual effects of migraine may originate either in the eye or in the brain. Ocular migraine, a loss of central vision (the scotoma), is due to disturbance in the
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retina, where vision to both sides is subserved. Hemianopic migraine is due to disturbance in the brain, where vision to each side is subserved by the opposite half of the occipital cortex. Regardless, the visual effects of migraine, whether originating in the retina or the cortex are, almost invariably, geometric hallucinations of vision. Always inanimate, there is never a hallucination of people, places, or recognizable things. Remarkable when you think about it. The dysfunctional brain of migraine expresses itself, at least visually, in abstract structural configurations. This occurs in no other disease. It is unique to migraine.

Somatic as well as visual sensation is disordered in the migraine aura, usually in a very lateralized manner. A sense of localized numbness and tingling is often a prodromal experience. It is usually confined to one side of the face but sometimes extends to the hand. Motor function is disturbed also, and it too is unilateral, consisting of transient weakness, usually in one arm. The function of speech, a unilateral left brain attribute, is frequently impaired. Word finding is difficult. Sometimes there is mutism, a total loss of speech, and occasionally a disorder known as fluent aphasia with nonsensical, word salad speech.

The temporal pattern of prodromal events is erratic. Most occur before the pain, but some during it. Regardless, the visual and auditory senses remain at attention throughout the headache. Exposure to light and sound worsen pain. The migraineur is photosonophobic. Thus, the quiet dark room offers refuge.

When the migraine headache does occur, it can be excruciating. It is typically unilateral (but occasionally bilateral) and pulsatile. Autonomic function is disordered with nausea, vomiting, and sometimes diarrhea. Transient hypertension may occur. Blood pressure may reach astronomical levels during a migraine attack. Thought may be disordered. A confusional interval as a manifestation of migraine is well known, as is the occasional transient ablation of