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Dexamethasone – Oradexon, Organon. The supply of cradexon needed in this study was donated by Organon, Indonesia.

MIGRAINE, RELATED HEADACHES AND PSYCHOTROPIC MEDICATION

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These observations result from previous experience with headache problems in a headache clinic in Switzerland, and from brief experience with headache problems in Malaysia, for little more than one year (by far not enough time for a statistical survey).

I have read two recent papers from this region: The Diagnosis and Management of Headache, by Loong Si Chin, and Complicated Migraine, by T.G. Loh and J.C. Chawla. I would like to comment upon a few concepts from these articles which may be representative of the interpretation of headache problems at an academic level in this region.

"Complicated migraine", say Loh and Chawla, "is not well known.....it is associated with protean ...neurological features...".

Migraine has been described by laymen from ancient Summerian and Egyptian times, and by Western medical authors (as far as their writings are extent) from the second century A.D., when the term was first introduced as "hemicrania" by Galenos of Pergamon, the father of Western medicine.

The best known variant of migraine is that hemicrania which is further characterized by preceding scintillating scotoma and concomitant nausea: the megrim, or sick headache, which had been described by Galenos and, as "heterocrania", by his precursor, Aretaios, wherefore it is often known as "classical migraine". In 1878, Galezowski gave it the self-explanatory name of ophthalmic migraine.

What Anglo-Saxon authors call "hemiplegic migraine", that is, a paroxysmal headache with transient features akin to some or all of the symptoms of stroke, had been named "migraine accompagnee" by Charcot, the founder of modern neurology, in 1887. The majority of cases of "complicated migraine,' can rightly be classified as migraine accompagnee.

The very rare condition of paroxysmal periodic headache with extraocular palsy was first identified by P. J. Moebius in 1884, and it was named "ophthalmoplegic migraine" by Charcot in 1890.

The migraine variant with the highest frequency of attacks which occur once to many times a day within bouts or "clusters" of one to two months is known in medical literature by at least twelve different names (such as: Horton's Neuralgia, Migranous Neuralgia, Erythroprosopalgia, etc.). In the last decades, American and Scandinavian authors have increasingly preferred "cluster headache", again a self-explanatory term.

On a sound historical basis, migraine and its variants can be classified as follows: common migraine, ophthalmic migraine, migraine accompagnee, ophthalmoplegic migraine, and cluster headache. There are other terms which have found less ready acceptance, such as dysphrenic migraine, characteristic migraine, basilar artery migraine. There is another, more comprehensive classification: the list of the ad hoc committee on classification of headache of the National Institute of Neurological Diseases and Blindness of the U.S.A., 1962, which includes facial migraine under a separate heading. However, the simple classification as proposed above takes care of the practically important forms of migraine, and allows us to get beyond the impression of "protean neurological features" and to sort out the "(infinite) variety of migraine" (Friedman) in terms compatible with contemporary literature.

In Anglo-Saxon literature, "Tension Headache"

comprises most forms of chronic headache without demonstrable underlying disease. In continental European texts, the term is usually replaced by "Cephalaea Vasomotorea". I know of only two features that enable us to distinguish this idiopathic chronic headache from migraine forms: namely, lack of response to vasoconstrictor agents, and lack of paroxysmal character. Even these criteria are far from absolute since literally every variant and every case of migraine may turn into the chronic headache syndrome, and lose its distinctive features. Any migraine variant may coexist with chronic headache in the same patient. Some chronic headache forms may respond to vasoconstrictive agents, especially to Dihydroergotamine. Since "muscle tension", most often in the form of cervical tendomyositis, is also one of the most common features of any long-lasting frequent migraine, I feel that we should regard "tension headache" and "cephalaea vasomotorea" as one and the same idiopathic chronic headache syndrome, and as the chronic equivalent of migraine.

Migraine is a paroxysmal disorder for which really significant correlations with other paroxysmal disorders have often been postulated but never demonstrated. It is associated with vasoconstrictive and vasodilatory phenomena, and with significant biochemical especially changes, in the levels of serotonin , and in the serotonin retention of platelets. It is most likely hereditary. It is very common. In 1959, Bo Bille found 3.9% migraine cases among nearly 9000 school children. As the same study showed, less characteristic headache forms were still more common: Bille found 6.8% "frequent nonmigrainous" headache, and 48% "infrequent nonmigrainous" headache. Since out patients tell us, as a rule, that their headaches began only after school age, it is very plain that migraine and its chronic equivalent must constitute one of the most common and ubiquitous groups of disorders.

It is astonishing, then, that hardly any doctor's practice is ever filled by headache patients. This is because headache alone is usually not the reason for patients to turn to medical help. It is only the worsening of chronic headache, or the onset of very severe headache, or the appearance of severe additional symptoms, which forces them to consult us. It was my constant experience that such worsening or, the precipitation of very severe attacks or continuous migraine attacks (status migraenosus) did very often coincide with changes in life situation which resulted in let down and frustrated resentment. This emotional background could best be established by taking note of the exact date of the worsening or precipitation, followed by asking about changes in family, job or housing situation at that time, or a little earlier. Once such a coincidence had been found, it was then often relatively easy to discuss the emotional values attached to the coincident change. These informations could then be used as the basis for a problem-oriented relationship which was usually combined with drug treatment. Frequently evidence of discrete or masked depression was found, which led to treatment with antidepressives, alone or in combination with migraine remedies. Migraine remedies were used in prophylactic, or long-term treatment. They comprised Ergotamine tartrate. Dihydroergotamine, Clonidine (Catapres), Sandomigran, Dimetotiazin, Methysergide. This method of treatment was used for both migraine and chronic idiopathic headache (Tension Headache, or Cephalaea vasomotorea).

The relationship of these forms of headache with emotional disturbances has been discussed since antiquity. The predominance of depressive disorders among the causes of headache *problems* has been emphasized before, e.g. by Habib (1972). However, the matter is far from closed; information about this relationship has never been systematically collected.

Loong Si Chin says, in his article in the SMA, 1972: "...treatment...usually presents no problem once a definitive diagnosis is made." I find it difficult to accept this statement. I have found that results of treatment in any not merely ephemeral form of headache can only be assessed after many years. This is why I cannot back up my empirical statements with a convincing statistical analysis. (My experience in my Zurich headache clinic is little more than five years).

Loong goes on to recommend "...tranquillizers or antidepressants for tension headache..." I believe that we should replace this indication by a more precise one, namely, "antidepressants for depressive conditions underlying tension headache and migraine problems." I think that doctors should try to identify these underlying disorders.

If we look closely at the drugs used in the treatment of headache, we find that many or most of them are psychotropic drugs. The indication for antidepressants has already been discussed. Dimetotiazine or Migristene is a phenothiazine derivative with a very marked sedative effect, chosen for its antiserotonine properties, but undoubtedly a true major tranquillizer. Sandomigran, also chosen for its serotonine antagonist properties,

has shown some antidepressive and sedative properties as well as appetite stimulating side effects which are the main reason why it appears to be more useful in Asiatic countries than in the saturated West. Dihydroergotamine had been designed as an agent exclusively related to the autonomic nervous system, but it has since proved to be effective in preventing the dangerous delirium which can arise from the combination of neuroleptics with tricyclic antidepressants. Methysergide, the chemical twin of LSD, chosen for its anti-serotonin properties, has been used for the treatment of mania. Serotonin itself is more and more recognized as one of the biochemical keys to psychic processes. Only Ergotamine tartrate cannot be characterized as a psychotropic drug – however its combination with caffeine is conducive, if used too frequently, to an unpleasant form of drug-dependence which is coupled with permanent daily migraine. In conclusion there is reason to suspect that most specific migraine treatment is at least partly psychotropic treatment, which may be administered without precise indication.

Another form of unwitting psychotropic treatment is the one most often administered by laymen, that is, analgetic treatment with painkillers. In Malaysia's outpatient departments, the Paracetamol reflex is paramount: complaints of headache lead to instantaneous prescription of Paracetamol . Paracetamol has not yet been exposed as having psychotropic properties, but it is clearly useless as soon as a headache has become a problem, that is, chronic or very severe. Other painkillers such as Saridon and APC-like combinations have been shown to be plainly psychotropic due to their combination of stimulating and sedative properties (Kielholz and Ladewig, 1970) which frequently lead to severe addiction. The double-blind controlled effect of these unspecific painkillers is generally in the range of a placebo-effect: for this reason, again, a predominantly psychological mode of action has been suspected, possibly enhanced by mild psychotropic effects.

It appears that we can hardly escape psychotropic medication in the treatment of migraine and tension headache. I believe that we should choose to administer psychotropic medication, not unwittingly, but consciously, and well knowing what it is that we are treating, as far as time limitations allow us.

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