9 Central Nervous System

9.1 Migraine, Vascular Headache and Premenstrual Tension

Approximately 10% of people in Western societies suffer from migraine or a variant at some point in their lives, but Crisp et al. [1] in a community of 5000 at Shipston-on-Stour reported the high figure of 25% in women. The incidence is higher than average in occupations demanding precise and sustained application of hand or brain, e.g. school teachers (about one in three), nurses, accountants and cashiers on the one hand, and tailors, embroiderers, watchmakers and lathe workers on the other. This appears to be due to autoselection [3]. People lacking the ability or willingness to maintain high standards, especially under pressure, gravitate to work that suits them better. Many patients with migraine also suffer from vascular (tension) headaches between attacks. These may be unilateral or bilateral and without nausea or visual phenomena. Because they may persist for days or weeks, sufferers find them very tiring and usually say they would prefer to have classical migraine which while of greater severity is of shorter duration.

In his book [2], Wolff recorded the most comprehensive account of the psychosomatic aspects of migraine to date. In it he said it was justifiable to include those “kindred headaches ... or migraine variants ... having in common vascular mechanisms”. He added that restricting the definition of migraine to classical migraine “results in profitless subdivisions of an overlapping headache syndrome”. We agree; these other syndromes include cluster headache, trigeminal migraine and hemi-anaesthetic and hemiplegic migraine. Had Wolff included the word migraine in the title of his book it would have greatly assisted retrieval by research workers and doctors who have followed him, and he would have received proper recognition for his outstanding contribution. Readers wishing to extend their knowledge of this disorder and its management are advised to read the 1948 and 1963 editions of Wolff's book because editions since his death have omitted much of value from the original account. The relevant chapters are 11 entitled, “The relation of life situations, personality features and reactions to the migraine syndrome”, and 12 on “Migraine therapy”. In these chapters he describes typicality of personality and attitudes and also typically provocative life situations, and illuminates the path a doctor or therapist needs to follow in order to achieve success. He stresses that a more direct approach than is acceptable in orthodox psychotherapy is more likely to succeed. Apparently Wolff himself had migraine, which may account for his unusual understanding. The following advice before starting any patient on treatment is as relevant today as when he wrote it in 1948: “The patient ... must appreciate that anything out of a bottle can offer no more than transient help.”
Paulley and Haskell [3] reported their experience of over 800 patients, and since then a further 800 have been treated by the same methods. The following recommendations are based on that experience.

9.1.1 Diagnosis and Examination

We have repeatedly emphasised the importance of full history taking and examination. This is never more important than when faced with a patient with migraine or migrainous headache. At the end of a comprehensive history, providing it includes some of the detailed enquiries and facilitations to be described, a doctor should be 95% sure that the diagnosis of migraine/vascular headache is correct. This must be followed by a full examination including the CNS, and it is nearly always advisable to X-ray the skull and to explain to the patient that although no abnormality has been found, it is almost certain that friends or relations will ask what tests the doctor did and if the answer is none, then the common reply is: “Well, that’s what happened to Uncle Bill, and he had a brain tumour.” Only once has a patient questioned whether this X-ray would show the brain, and he was sent for a CAT scan! This investigation is rarely necessary, but unfortunately in some parts of the world the nadir has already been reached of patients being referred to physicians or neurologists as “headache – CAT scan negative”!

Some Essentials in History Taking for Patients with Headache. Although “organic” non-migrainous causes account for no more than about 5% of patients presenting in general practice or hospital with headache, the doctor’s first responsibility is to exclude these by detailed questioning and examination. This enquiry must cover the characteristic features of the headache in such conditions as raised intracranial pressure, sinusitis, giant cell arteritis, retrobulbar neuritis and glaucoma. At the same time one will be listening for clues pointing to a diagnosis of migraine, migrainous equivalents or vascular headache. Some of these clues can only be elicited by taking a psychosomatically orientated history in which the presence or absence of the typical personality traits and attitudes found in migraine will be of paramount importance. If these are absent, clinicians should suspect some cause other than migraine. However, many patients with migrainous/vascular headache are told without supporting evidence that they have sinusitis or sinus headache and as a result may suffer for years with the wrong diagnosis and without appropriate treatment. Such patients attend saying: “I’ve got my sinus again” ([4] p. 665). The reason why many patients with a history of attacks of classical migraine also suffer between attacks for days or weeks from persistent vascular (tension) headache is unknown. However, it seems to be related to the fact that classical migraine occurs after periods of tension and overactivity in the “let down” period at weekends, the first day of a holiday or even heavy sleep, whereas vascular (tension) headache seems to be associated with periods of unremitting tension without intervening phases of relaxation.

Typicality of Profile and Multicausality. It has been questioned whether there is a typical profile in migraine on the grounds that other people may have it, or may appear to have it, without having migraine. While this may be true, it does not mean