THE MANAGEMENT OF MIGRAINE

Significant progress in the management of what H. G. Wolff termed "man's most prevalent distress" is unlikely until presumably authoritative writers and the vast majority of practicing physicians abandon unproved and unscientific concepts, reliance on anecdotal experience, and semantic misnomers. Notions of such alleged entities as "histaminic cephalgia", "allergic headache", "sinus headache" (excluding acute suppurative inflamation), "eye-strain headache" and a host of others persist in common medical parlance for ordinary vascular headache (HA) and continue to provide convenient handles for (mis)management which assuage the physician's conscience and dupe the patient. The fact that the patient often improves -- temporarily -- protracts this unintentional charlatanry.

Though all the links in the chain of pathogenesis remain yet to be ascertained, for practical purposes recurrent (HA's)unassociated with demonstrable intracranial, extracranial, or paracranial disease should be considered as owing to cranial artery distension, with or without components of sustained cranial muscle contraction. The criteria for distinguishing purely muscle contraction HA's from vascular HA's are tenuous and vague. If "tension" HA's exist, they form but a small fraction of the vast army of vascular HA (migraine) sufferers, constituting 10% of the world's population.

For HA's of moderate intensity a nap, with or without aspirin or APC, often suffices. Strong black coffee and aspirin(with or without barbiturate) is effective in a few subjects. The mystique of the therapeutic specificity of "Fiorinal" for "tension" HA needs to be disspelled with the realization that it is merely APC combined with barbiturate. When HA is too severe to respond to simple analgesics, caffeine, and/or sedatives, more intensive pharmacotherapy directed toward cranial vasoconstriction is indicated.