

Ergotamine tartrate (Cynergen) is the best agent, most predictably effective intramuscularly or intravenously, but also, in perhaps 2/3 of subjects, orally (sublingual or ingested), rectally, or inhaled via spray atomizer. Its combination in proprietary preparations with caffeine (also a cranial vasoconstrictor) for oral or rectal administration appears to enhance its effect. In isolated failures there is little choice but to fall back on potent narcotic analgesics such as meperidine (Demerol) or codeine. The necessity for several hours or a day's rest following relief from a headache is usually neglected by the physician or ignored by the patient.

Though the availability of reasonably predictable relief from a nagging headache or an acute "splitting" hemicrania is reassuring knowledge to the patient, the most desired aspect of management most certainly is prevention of recurrent attacks. No drug to date, whether by controlled or impressionistic trials of therapy, has been shown to be predictably or permanently effective in eliminating attacks in a majority of cases. An advantage over placebos has been demonstrated in some agents, including methysergide (Sansert); rarely with preventively administered ergotamine tartrate (alone or in combination with barbiturate sedative and other questionable agents, in cautiously planned regimens); inderal (Propranolol), and opipramol (Insidon), but the reliability of these imperfect trials of therapy and experience to date have not yet been adequate to warrant their routine use with confidence by the physician.

None has been shown to be more effective than conscientiously and sympathetically applied psychotherapy. Once the migraine personality becomes well known to the physician and he develops increasing skill in dealing with it, including assistance to the patient in modifying his attitudes, habits of living, patterns of emotional reaction, and/or environmental stress, the results are as good as with prescribing anything that comes out of a bottle.