ANTIE

TREATMENT OF MIGRAINE:

Migrane is a familial disorder characterized by Recurrent attacks of ~~Recurrent attacks~~ of headache widely variable in intensity, frequency of duration. Attacks are commonly unilateral & usually Associated with Anorexia, nausea & vomiting

Triggered by: Food, Disturbed sleep pattern, physical exertion, visual Auditory, olfactory stimuli, Hunger, physiological factors.

PHASES:
- Prodrome
- Aura
- Headache
- Recovery.

Prodrome → begin from 12 hours to 86 hours befor the Aura & headache.
Symptom: Irritability, yawning, excessive sleepiness.

Aura → warning befor headache
symp: Flashing of light, zigzag lines, Difficulty in focusing

Headache → unilateral & is Associated with
symp like: Anorexia, Vomiting, Nausea, Photophobia.
Fatigue

Postdrom → Fatigue, Depression, & over exhaustion.

MIGRAINE

without Aura (common)	with Aura (uncommon)/classic
→ Unilateral throbbing headache may be accompanied by nausea & vomiting	→ Unilateral throbbing headache later become generalized
→ c/o phonophobia, photophobia	→ c/o visual disturbance & may have mood variation.
→ No Aura or prodrome	

PATHOPHYSIOLOGY:

- Vascular theory
- neurogenic theory.

Vascular theory:

- Initial vasoconstriction of blood through carotid Artery causes Ischemia produce cerebral ischemia ↓ starts the Attack.
  - : Intracerebral vasoconstriction - Aura (↑ serotonin)
  - : Extracranial vasodilation - Headache (↓ serotonin)

↓ during Attack

so there is change in B.V stimulate to trigger pain receptors.

Neurogenic theory:

- spreading depression of cortical electrical Activity. followed by vascular phenomenon.

↓ due to hypersensitivity to sound, light,

Release of mediation like → neurokinin, substance P, CGRP, Nitric oxide

MANAGEMENT:

Non-Pharmacological Tx
- → Meditation
- → Psychotherapy
- → Relaxation training
- → Identification of triggers.

Pharmacotherapy:
- Abortive therapy
- Preventive therapy

Drug therapy:

- → Mild Migraine → simple Analgesics / NSAIDS.
- → Moderate → NSAIDS triptan / ergot
- → severe → β blockers, Ca^{2+} channel blockers, Valproate.

MIGRAINE → More effective migraine without Aura

Aspirin, Paracetamol / Ibuprofen, Diclofenac

↓

IM/ORAL

RANKA
DATE / /
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Specific t/t:
Ergotamine : oral 1-2mg/d
dihydroergotamine: Parenteral 0.75-1mg.

Antiemetic drug t/t:
→ Domperidone 10-20mg/day.
→ Metoclopramide 5-10mg/day.

ERGOT ALKALOIDS IN MIGRAINE:

Ergotamine: (Most effective Alkaloid).
Action - constricting of the dilated cranial vessel & by specific contriction of carotid A-V shunt channels.
- Best Result when attacked in prodromal phase.

Dihydroergotamine (I.V Administration)
For intractable Migrane

TRIPTANS → Inhibit Release of Inflammatory neuropeptids.
Sumatriptan → contricts dilated Blood vessels, especially A-V shunts.
Ad→ Better than ergot
suppress Nausea, vomiting.
Dis→ short duration of Action.
Bradycardia

MIGRAIN PROPHYLAXIS:

→ who have frequent attack (2-3 more per more) duration >48hrs., ex
- BBlocker (gold std method)
  ↳ Propranolol, Metoprolol,
    ↳ Most commonly used.
- Ca2+ channel Blockers:
  Flunarizine, Verapamil.
- CGRP Antagonist
  - Erenumab, Injected SC once month in patient with severe migrane