

Letters to the Editor

A ruptured spinal AVM in a patient with migraine

To the Editor

Dr F. Maggioni et al. (Cephalalgia 1995;15:237-40) have published a Case Report of a ruptured spinal arteriovenous malformation which initially presented with migraine-like manifestation. While the report makes interesting reading, I seek clarification from the authors on a number of the issues and conclusions they have arrived at:

- (1) Was it not a matter of pure chance that in the absence of signs suggestive of spinal involvement they undertook an MRI exploration of the whole CNS and found a spinal AVM?
- (2) Can they attribute the headache to the lumbar bleed and explain it on the basis of trigeminal nociceptive receptor stimulation, based on the

fact that the patient was a predisposed migraineur?

- (3) Are they justified in suggesting extensive search for a spinal AVM in the absence of symptoms or signs of medullary or spinal root involvement?

Although they have struck gold in an isolated case, I wonder whether all clinicians would agree with their line of approach and search for a spinal AVM even in the absence of symptoms or signs of spinal involvement. I feel that the availability of a hightech modality should never be an indication for further investigation in the absence of clinical signs; therefore, in my opinion, this Case Report might have been more appropriately entitled "An interesting case of a ruptured spinal AVM in a patient with migraine".

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A reply to Ravishankar

To the Editor

We would like to thank Dr Ravishankar for his interest in our paper: "Initially migraine-like manifestations of a ruptured spinal arteriovenous malformation" (Cephalalgia 1995;15:237-40).

Regarding his questions: We deliberately explored the whole CNS. In fact, the relevant blood contamination of spinal fluid detected with lumbar puncture brought to light the problem of such a massive bleeding inside the CNS. Therefore, despite the negative findings on brain, we considered that an extensive MR investigation of the spinal cord had to be performed before arriving at a diagnosis of subarachnoid hemorrhage "sine materia".

We deem it a likely hypothesis, as already reported in discussion of our paper, that, considering the possible migration of subarachnoid blood from spinal to cranial level, the stimulation of the

trigeminal nociceptive receptors could have triggered migraine-like symptoms in a predisposed migraineur.

Finally, we agree that the use of a high technology modality must be guided by clinical judgement and not performed routinely and merely on the basis of its availability. However, considering the relevant consequence of not detecting curable causes of bleeding, as in this case, the issue should probably be addressed with a study of selected patients with apparent subarachnoid hemorrhage "sine materia" in order to evaluate the real occurrence of conditions like the one we have described: only then could we claim to have struck gold (albeit a very little nugget) from a single case.

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Delayed urticaria with sumatriptan

To the Editor

Sumatriptan is a remarkable treatment for migraine attacks (1). The most frequent adverse effects are a feeling of thoracic pressure, or of tightness, dizziness,

tingling and flushes. Allergic manifestations are rare (2-4). A case is reported below.

A 37-year-old man with no significant medical or surgical history had complained of attacks of migraine since the age of 18-20 years. For four years