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Headache is one of the most common of medical complaints but in spite of this it still remains largely underdiagnosed, undertreated and also neglected in medical teaching. Migraine is the most common cause for disabling headaches that are seen in practice. The World Health Organisation (WHO) in their recent report¹ identified migraine to be among the world's top 20 causes of disability, with an impact that extends beyond the suffering individual. Migraine is estimated to account for 2.0% years of life lost due to a disability in women of all ages. In both sexes, migraine is responsible for 1.4% of total years of life lost due to a disability. This landmark report establishes the burden of migraine for the very first time after collecting information on headache from around the world. These results are anticipated to have long-reaching impact on individual sufferers, their caregivers, family and on society itself.

Migraine begins before the age of 20 in 50% and produces maximum disability during the peak productive years of a sufferer's lifetime. The cumulative life time incidence of migraine in the population is 43% for women and 18% for men. But in spite of the high prevalence and huge burden, migraine sufferers are often not correctly diagnosed and when they are diagnosed correctly they are treated suboptimally.

Rapid advances in headache science over the last two decades have contributed to the recognition of primary headaches as real diseases. As a result of advances in migraine genetics and as a result of better understanding of the pathophysiology and designer drugs like the triptans, there has been a growing interest in this field. Migraine recognition has also improved following on the International Headache Society's Classification of Headache Disorders (1988,2004) and specific diagnostic criteria have uniformised diagnosis and treatment. Migraine is therefore now well established as a disorder of the brain, where the trigeminal neuronal pathways are most importantly involved and the vascular changes are a secondary epiphenomenon of these neural events.

The migraine spectrum has also expanded considerably. New entities have been included, criteria have been modified and some pediatric migraine syndromes have been extended official status. Epidemiologic studies have confirmed the concept that migraine can evolve from an episodic pain disorder to a chronic form that can be highly disabling. This chronic nature of migraine was not completely understood and accepted at the time of the first 1988 classification. Chronic migraine is now included as a complication of migraine in the 2004 classification. This emphasizes the need for a change in therapeutic goals based on recognition of comorbidities and risk factors that contribute to the transformation. Prevention is therefore key to ideal migraine management. There are newer abortive drugs being tried out and trials with new prophylactic agents and devices are in the pipeline. It is therefore imperative that in 2009, we look at migraine differently rather than just as another benign headache that affects neurotic individuals and for which there is no cure and one that will go away with age!

In this special issue we have made an attempt to tie up the salient features that are current in the field of migraine.

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The concluding article outlines the new understanding in migraine and explains why migraine needs to be conceptualized differently. Newer pathophysiological concepts are detailed and recent additions to the field of migraine have been discussed.

Because it is a heterogenous entity and because it can manifest across all age groups, the diagnosis is not always straightforward and easy. The difficulties in diagnosis, the close differentials and the special situations where migraine diagnosis should not be missed is discussed in the article on the article on 'Pitfalls in Diagnosis'.

In its pure form, migraine is easily recognized but it is a spectrum of clinical presentations that is continuously expanding. A number of these entities have now been officially included under the migraine category in ICHD2 but there are still many variants that are in borderland territory and where the understanding is still not clear. These "migraine variants" are often seen and missed in practice. Studies have shown that migraine is comorbid with a number of disorders. These comorbidities support the view that migraine is a brain disease with links to other such brain disorders. Comorbidities can play an important role while deciding on long term prophylaxis.

Research over the last two decades following on the launch of the triptans – designer drugs that are serotonin receptor 5HT - 1B/ 1D/ 1F agonists has resulted in the introduction of new acute abortive pharmacological agents. Acute or abortive migraine management encompasses specific and non-specific agents and they are discussed in the article on 'Acute Treatment Options'.

Prophylactic migraine management spans the pharmacological spectrum from anti-epileptic and anti-hypertensive agents to botulinum toxin type A. There are specific indications, goals and ways to select and combine from amongst the numerous prophylactic drugs that are currently available.

Despite all these scientific advances, migraine management is still very much an Art. There is no single correct ideal approach; migraine treatment is still very much a trial and error process and the management plan must typically be customized to suit the needs of individual patients. With all this new understanding, migraine patients can now be optimistic and positive about a brighter future than to live with the stigma that they were used to in the past.

References

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