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MIGRAINE RELATED DISORDERS

ACEPHALGIC MIGRAINE

A 7-year-old girl presenting with a one year history of intermittent migraine auras without headache, a maternal grandfather similarly affected, and a mother with common migraine are reported from McGill University and the Montreal Children's Hospital, Canada. The child's auras consisted of intermittent brief episodes of visual disturbance, white spots, flashes of colors, and metamorphopsia, with faces appearing smaller or larger than normal. The episodes lasting up to 5 minutes often occurred daily. Headache was denied, and the neurologic exam, EEG, VER, and CT were normal. The grandfather's migraine auras consisted of a shimmery white line moving across the visual field from left to right, they lasted up to one hour, were never associated with headache, and attacks resolved spontaneously in his mid-50s. (Shevell MI. Familial acephalgic migraines. Neurology March 1997;48:776-777). (Dr Michael I Shevell, Room A-514, Montreal Children's Hospital, 2300 Tupper, Montreal, Quebec, Canada H3H 1P3).

COMMENT. "Migraine-sans-migraine" was first described by Whitty CWM (1967), at the Radcliffe Hospital, Oxford, England. Subsequently termed acephalgic migraine (migraine aura without headache) in the International Headache Society (IHS) classification (1988), the entity has recently been described in a series of children and estimated at a frequency of 2% among children with migraine (Shevell MI, 1996). The author cites only one other published report of familial acephalgic migraines (Ziegler DK, 1995).

Migraine without aura, diagnosed by clinical criteria, was not confirmed by IHS criteria in more than two thirds of a group of children whose records were analyzed at the Schneider Children's Hospital, New Hyde Park, NY. (Maytal J et al. Neurology March 1997;48:602-607). IHS criteria for diagnosis of migraine without aura in children may be too specific and complex and poorly sensitive in practice. The authors suggest that IHS criteria

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should be modified to accommodate clinical pediatric manifestations and omit those symptoms infrequently observed in children, eg unilateral headache, phonophobia. The restrictive nature of IHS adult criteria for migraine diagnosis in children is discussed in Progress in Pediatric Neurology III, PNB Publ, 1997.

Effective migraine management is reviewed from the Institute of Neurology, Queen Square, London (Goadsby PJ, Olesen J. Neurology March 1997;48(Suppl 3):S1-S3). **Acute treatment of migraine with dihydroergotamine nasal spray** is reported from the University Headache Center, Moorestown, NJ. (Gallagher RM et al. Arch Neurol Dec 1996;53:1285-1291). Newer and experimental treatments for migraine are generally inappropriate for use in children. Analgesic or analgesic/antiemetic combinations are first-line acute treatments. Greater attention might be given to precipitating factors, including diet, school-related stress, and negative parent responses to the headache.

PARENT RESPONSES TO PEDIATRIC HEADACHE

Parent and child report measures of the frequency and quality of parent responses to children's recurrent headache were evaluated for 153 pediatric patients at the University of Maryland School of Medicine, Baltimore, using a 16-item scale modeled after part II of the West Haven-Yale Multidimensional Pain Inventory, which assesses patients' perceptions of others' responses to pain, and a Child Behavior Checklist, to assess parent perceptions of the child's behavioral responses. Parent-perceived negative responses (eg. ignore, leave room, frustration) were correlated with increased levels of behavior problems in adolescents. Parent affiliative or distracting responses (eg. talk or read to child, express sympathy) were associated with lower levels of functional disability in younger children. (Wall BA, Holden EW, Gladstein J. Parent responses to pediatric headache. Headache Feb 1997;37:65-70). (Respond: Dr E Wayne Holden, Department of Pediatrics, University of Maryland School of Medicine, 630 West Fayette Street, Room 5-668, Baltimore, MD 21201).

COMMENT. As might be expected, parental negative response to pediatric headache is an important factor in causation of functional disability and behavioral problems associated with recurrent pain. To prevent the development of behavioral problems, parents of children 11 years of age and younger should reinforce symptom-free periods and use distractions and supportive comments in response to pain-related behavior. Parents of adolescents should be over solicitous and should avoid negative or punitive responses.

HEADACHE AND CHIARI-I MALFORMATION

The clinical features and pathogenesis of headache associated with Chiari-I malformation and syringomyelia are reviewed from the Katholieke Universiteit Leuven, Belgium. The incidence of headache reported with Chiari-I malformation has varied from 12 to 58%. In a retrospective review of 62 cases of syringomyelia, only two had headache as a presenting symptom. Chiari-I headache is paroxysmal or protracted, occipital in location, aggravated by Valsalva's maneuver, effort, cough, and postural changes, and correlates with the degree of tonsillar herniation. Syringomyelia may coexist with Chiari-I malformation, but has no relation to the occurrence of headache.