Migraines Part 2:
Migraine Management

By: Gary E. Foresman, MD

In our last article we focused on the pathophysiology and "natural" approaches to migraine prevention. For many migraneurs even after learning and practicing stress-reduction, evaluating gastrointestinal health, eliminating food allergies, and good detoxification, they may still continue to have continuing, disabling headaches. For these people, we begin supplementing as discussed in my last article. Where Western medicine excels is in the acute "abortive" treatment of migraines, and when necessary, medically supervised regimens for migraine prevention.

Since 1993 and the release of Imitrex (sumatriptan) a new era in the treatment of acute migraine has been launched. The "triptans" are 5HT 1B/1D receptor agonists, meaning that serotonin receptors do play a role in migraine headache. What most people don't understand is that these receptor sights have more to do with inflammation, and nothing to do with depression or "serotonin" as we have been taught about it from the media. They are safe, effective anti-inflammatory medicines when used acutely and at most twice per week. Although seven members of this family of medicines exist, studies conclude that Imitrex 100mg orally or 6mg as a shot is the gold standard by which other triptans are judged. The use of Frova (frovatriptan), especially for menstrual migraine, and other triptans depends on individual variations and responses to medicines. An absolute requirement is treating at the earliest possible sign of migraine. In patients who develop the skin sensitivity so common in migraines (called cutaneous allodynia), if one waits too late to treat with a triptan, the medicine become enormously ineffective.

Other abortive medicines include over-the-counter Excedrin, and prescriptions such as Midrin, Fiorinal, and a nasal spray known as Migranal. If one does not respond to triptans, these make fine alternatives under physician supervision. If anyone uses any total of these abortive medicines more than twice per week, they are at high risk for "rebound" headaches and getting into a descending spiral of medication abuse. The only natural abortive treatment that I have found extremely effective is the use of IV nutrients, specifically magnesium with B-complex and B-6 given as a slow IV push.

If one suffers more than 2 migraines per month, treatment with a preventive medicine should be strongly considered. Before going into the newer medicines, do not forget to work with your physician using the older, tried and true medications which include:

- **Amitryptiline** 10-50mg nightly can dramatically reduce the hypersensitivity cycle and also improve sleep quality.

- **Beta-Blockers** such as Inderal LA (propanalol)and others especially in those with significant stress-related symptoms.
- **Calcium Channel Blockers verapamil SR** – effective and no, it has no effect on your body's ability to absorb calcium or bone health.
- **Depakote ER** in a class of medicines known as anti-epilectics, they tend to have far too many side-effects. This is the best tolerated and most effective in the older class of anti-epilectics.

Two newer preventive treatments that should be mentioned include Topamax which only needs to be dosed as high as 100mg after being started at 25mg once per day. Also in the anti-epilepsy class of medicines, it also has potential toxicities and the scandalous misuse of Topamax as a weight loss agent by people who claim to be "metabolic specialists" is a travesty against nature itself. Topamax does cause a mild acidosis at low dosages that can cause a mild suppression of appetite, but higher dosages cavalierly tossed into unsuspecting patients can lead to severe metabolic acidosis and eventual death, the supreme appetite suppressant. However, at low doses of 50-100mg, it is definitely useful for refractory migraneurs, and under the careful supervision of Board Certified Neurologists, higher doses of Topamax can and should be used for the condition of epilepsy, the condition for which it was intended.

Finally and most importantly, I have come full circle on my views of Botox in the treatment of not only migraine headache, but also in the difficult to treat patient with chronic daily headache. Botox is the safest of all preventive medicines, as there has never been a case fatality associated with its use. Despite a hefty price tag of nearly $500 per vial, it has also been shown to be cost effective due to the decrease in usage of other medicines and medical services. In someone skilled in injections, we use the "follow the pain" method of injecting and remarkable results can be seen within weeks of the first series of injections. Injections need to be repeated every three months for the first year, and variably thereafter. Let me reiterate, Botox is the safest preventive medicine for migraneurs, and the only limiting factor in terms of its further widespread usage has been the reluctance of insurance companies to cover this safer, more cost-effective treatment.

With a holistic perspective and most importantly, trust and respect between the patient and the physician, most all headache syndromes can be effectively treated. With a healthy and holistic perspective I encourage the migraneur to visit their primary care physician first and foremost. Migraneurs need to understand that it may take many trials of many different supplements and/or medicines, and if the patient is unable to get the results they are looking for, then certainly evaluation with a headache specialist is in order.

Your Journey to Health and Healing,
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References:

Upon Request

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