43. (A30) The role of diet in migraine

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Twenty-four migrainous patients were randomly placed in 3 sequential diets, A, B, and C. Each of the diets was given for 6 weeks. During the dietary period A, the patients ate foods containing tyramine and avoided tyramine-free foodstuffs. During diet B, they consumed tyramine-free foods and excluded tyramine containing ones. During diet C, they ate and drank ad lib. The results showed no significant difference in the severity of migraine in any particular diet. We also determined whether the headaches were time-locked to any specific food or fasting by evaluating all patients as a unit. The food scores were obtained by rating the headaches that occurred within 12 hours from the time of the particular food ingestion and relating them to the total number of days that the specific food was consumed. Similarly, the fasting score was obtained by rating the headaches time-locked to fasting. The three maximum scores were reached by alcoholic drinks, chocolate and fasting. The foodstuff with the highest tyramine content, cheese, had a low score similar to hamburgers. We have concluded that the diet is a relatively unimportant factor in migraine except, probably, for alcoholic drinks, chocolate and fasting.

44. (A30) A study of Rivotril (clonazepam) in migraine treatment

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Our findings so far indicate that Rivotril sometimes certainly has a beneficial influence on migraine. Other types of headache were unaffected. Rivotril can be used as a prophylactic as well as for relieving an attack. The doses needed can vary considerably. The pharmacological action of Rivotril in migraine is unknown.

45. (A30) Migraine with isolated abducens nerve palsy

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Ophthalmoplegic migraine is a rare but established clinical entity in which one or all of the cranial nerves supplying the extraocular muscles are affected. Oculomotor nerve palsy is the most frequent affected, whereas an isolated sixth nerve palsy is very rare.

A 12-year-old boy presented with a 6-month history of recurrent, throbbing, hemicranial pain, not preceeded by an aura, but regularly associated with diplopia. Examination revealed an ipsilateral sixth nerve paresis appearing with onset and disappearing with cessation of throbbing pain. Visual acuity was not altered during the attack and the patient was otherwise normal. A cine-recording of the paresis has been obtained. Neuroradiological investigation including CT scanning has failed to demonstrate any abnormality. A maternal aunt has hemiplegic migraine.

Attention is drawn to three interesting aspects: (1) No visual impairment accompanies the ophthalmoplegia nor was there other evidence of squint. (2) A family history of hemiplegic migraine is present. (3) Throbbing pain rather than an aura is regularly accompanied by ophthalmoplegia. The observations suggest that pain is either not caused by vasodilatation or that vasoconstriction of some cranial vessels may occur concomitantly with vasodilatation in other areas of brain and/or scalp.

46. (A30) The vertebragenous headache

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The importance and high incidence of the vertebragenous headache is pointed out. The vertebragenous headache is classified as a symptom group of the upper cervical syndrome. Concerning the etiology of the vertebragenous headache there is hypomobility or hypermobility of the upper joints of the cervical spine (blocked-up headache or anteflexion headache according to Gutmann). Disturbed blood supply in the vertebral basilar arteries can be the cause of another symptom group of the upper cervical syndrome. The neurological and the orthopedic status show typical findings following an exact program. The therapy has to be grouped into an acute phase and an individual rehabilitation, using the reflex and manual therapy as well as relaxing medicaments.

Novel Biochemical, Pharmacological and Clinical Aspects of Cytidinediphosphocholine

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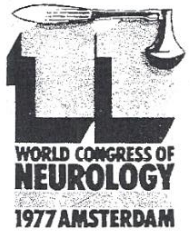

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