Expert Opinion

Migraine Versus Probable Migraine

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Key words: migraine, probable migraine

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“...You say either and I say eyether, You say nei-
ther and I say nyther; ...You say laughter and I say
lawfter, You say after and I say awfter...” (excerpted
from George and Ira Gershwin’s song, “Let's Call the
Whole Thing Off,” sang by Fred Astaire in the 1937
movie, “Shall We Dance.”)

CLINICAL HISTORY

A 77-year-old man has a history of similar recur-
ring headaches since he was a teenager. For years, the
headaches would occur about one time per month,
but for the last 5 years, they occur about once per
week. He reports a left frontal-retro-orbital aching
non-throbbing pain without associated aura, nausea,
vomiting, and light or noise sensitivity. Untreated
headaches can last 1 day. Ibuprofen or sleep may help.
The headaches have a moderate to severe intensity
and may interfere with activities. The only trigger is
stress. He has no other headaches. His mother had sick
headaches.

Question: What is your diagnosis?

EXPERT OPINION

This man’s headaches are best classified as “prob-
able migraine without aura.” The International Clas-
sification of Headache Disorders—2nd edition of the
International Headache Society (IHS) diagnostic cri-
teria1 for “probable migraine without aura” require
that attacks fulfill all the criteria but one for the diag-
nostic criteria for migraine without aura. This man’s
headaches are not pulsating, but have three of the
other four pain characteristics and only two are re-
quired. The headaches are probable without aura, rather than typical migraine without aura, because one
important feature is missing, namely one of the accom-
panying symptoms: either nausea with or without vom-
iting, photophobia, and phonophobia (see Table).2 Al-
though hypersensitivity to light and noise was not
overt in this patient, his behavior during an attack may

Table.—Features of Migraine Without Aura2 (n = 342)

<table>
<thead>
<tr>
<th>Pain characteristics</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral location</td>
<td>55</td>
</tr>
<tr>
<td>Pulsating quality</td>
<td>82</td>
</tr>
<tr>
<td>Moderate or severe intensity</td>
<td>100</td>
</tr>
<tr>
<td>Aggravation by routine physical activity</td>
<td>97</td>
</tr>
<tr>
<td>Accompanying symptoms</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>87</td>
</tr>
<tr>
<td>Vomiting</td>
<td>45</td>
</tr>
<tr>
<td>Photophobia</td>
<td>94</td>
</tr>
<tr>
<td>Phonophobia</td>
<td>82</td>
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</tbody>
</table>

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have suggested otherwise. As recently noted, most migraineurs when answering “no” to the question “does light or noise bother you during a headache,” will relate that they prefer a quiet and dark room during the attack. In a French study using IHS 2nd edition criteria of a representative sample of 10,532 adult subjects interviewed, 11.2% were diagnosed as having strict migraine and 10.1% as having probable migraine.

In some instances, even two criteria may be missing and I would still consider the headaches as a form of migraine. For example, if this patient’s headaches were of short duration, ie, $3\frac{1}{2}$ hours rather than the required minimum of 4 hours, the headaches would not be classifiable by the 2004 IHS standards. But what headache other than migraine would manifest unilateral pain, recur about once a month, begin in the teens, and last for most of one’s life? The IHS classification is an excellent tool for research, but need not be considered the “Bible” with regard to clinical practice.

One can only speculate about the reason for increased headache frequency for the past 5 years in this 77-year-old man. At this age, some subclinical hemodynamic change is most probable. Nevertheless, a treatable organic disease must be considered when a new headache or, as in this case, a change in headache pattern occurs in late adult life. And for this reason, an imaging study would be warranted.

REFERENCES