New research on migraine with aura, heart attack and stroke

3rd EHMTIC held September 2012 in London

TV weatherman Michael Fish supports Remember A Charity

Walking, cycling, climbing and kayaking for The Trust
Dear Readers

Happy New Year from The Migraine Trust.

We had a very successful 2012, seeing the expansion of our Advocacy Service; reaching out to individuals who were so severely affected by migraine that it was affecting their day to day job. We have seen some significant achievements: helping sufferers improve their quality of life, stay in work, and advocate for themselves in future. We have also worked on improving the way in which we deliver high quality, evidence-based information to individuals affected by migraine.

Perhaps most importantly, we have invested in a new area of migraine research which you can read about later in this issue.

Our third joint European Headache and Migraine Trust International Congress (EHMTIC), was held in London on 20-23 September 2012 and was very well attended by scientists, clinicians and medical experts from across the world, meeting to discuss the latest research and advancements in migraine and headache.

The public day held on the Sunday was particularly successful, with every delegate rating the event as either ‘excellent’ or ‘good’. We were very pleased to have a broad range of speakers, experts in their field, giving a summary of the research presented at the congress and talking through the new NICE guidelines for headache. We were delighted that our own trustee, Professor Peter J Goadsby, one of the world’s leading experts in migraine and headache, gave the final presentation of the day and left attendees feeling inspired that research has made significant improvements to the understanding of their condition and potential new treatments.

I would like formally to welcome Sir Denis O’Connor and David Cubitt as new members on our board of trustees. They both bring exceptional skills and experience, strengthening the charity at board level. You can find out more about our board members, both old and new, at migrainetrust.org/trustees.

We were also pleased to welcome Charles Bosher as our new Head of Fundraising & Communications; I am sure you have already heard from him and he has much planned in the forthcoming months to ensure you are kept up to date with key developments.

Finally, I would like to thank you, our supporters, who make our work possible. Our work is entirely funded by voluntary donations and it is only with your support that we are able to reach out to an increasingly broad audience, many in real need of your support and guidance.

Your donations have helped us reach thousands of sufferers, in both health and employment terms, and critically have allowed us to invest in an exciting new area of migraine research that could lead to new treatments and a better understanding of the condition. So for this, thank you very much. Have a happy and healthy 2013.

Warm Regards

Wendy Thomas, Chief Executive
NICE guidance on Botox

The National Institute for Health and Clinical Excellence (NICE) issued guidance in June 2012 recommending that Botox® (botulinum toxin type A) is made available on the NHS as a possible preventive treatment option for some adults with chronic migraine. Local NHS healthcare providers in England and Wales must now ensure that funding and resources are in place for eligible patients to access the treatment following recommendation by a suitably qualified health professional. Access to the right drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you, is a patient right enshrined in the NHS Constitution.

More information about the eligibility criteria is available on the NICE website www.nice.org.uk

Migraine and welfare benefits

The Department of Work and Pensions (DWP) commissioned an independent review of the Work Capability Assessment (WCA), which is an assessment for Employment and Support Allowance (ESA). ESA is a welfare benefit for people with an illness or disability that limits or hinders their ability to work. The Migraine Trust submitted a response to the call for evidence to inform the review based on the views and experiences of migraine sufferers who had contacted us. The final review, published in November, concluded that the WCA is an effective assessment method but needs to be made fairer and more effective by improving both the process and the technical descriptors used to assess eligibility.

More information, including a copy of The Migraine Trust’s response and the published review, is available in the Policy section of our website.

The Disability Strategy

In March 2012 The Migraine Trust submitted a statement to The Office of Disability Issues to inform a new cross-government Disability Strategy that is in development.

Two documents were published in September 2012 summarising the findings and the principles that will guide the Government’s future work in this area. The Migraine Trust is pleased that the key messages outlined in our response are reflected in the documents and that The Migraine Trust was quoted and referenced on the need for more awareness and flexibility to support people with a long-term fluctuating and episodic health condition to retain their employment through periods of illness.

Work on the strategy will continue into 2013. The Migraine Trust will continue to monitor the strategy’s development to ensure that the needs of migraine sufferers, for whom the condition is a disability, are addressed.

For more information and to stay informed visit the Policy section of our website.

NICE headache quality standards in development

Following on from the Clinical Guideline on Headache published by the National Institute for Health and Clinical Excellence (NICE) in September 2012, development of quality standards is now underway in this field. A NICE quality standard is a concise set of statements designed to drive and measure priority quality improvements within a particular area of care. The Migraine Trust’s Chief Executive Wendy Thomas is representing migraine sufferers on the Quality Standards Advisory Committee as a specialist lay committee member.

For more information on the NICE Headache Guidelines see page 5.

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For more information on the NICE Headache Guidelines see page 5.

Advocacy toolkits now available

The Migraine Trust now has two toolkits to help migraine sufferers to advocate for themselves in employment and when accessing treatment on the NHS. The toolkits provide information and guidance on sufferers’ rights and the options available to them as well as template letters and forms.

The toolkits are available in hard copy or to download from the Advocacy section of our website.
Strategic Clinical Network for Neurology

The NHS Commissioning Board confirmed in July 2012 that it will be establishing a Strategic Clinical Network (SCN) for neurological conditions, under which dementia and mental health will also sit. SCNs, which will be funded and administered by the NHS, are intended to bring together primary, secondary and tertiary care clinicians alongside partners from social care, the third sector and patients, to define and advise commissioners on evidence based best practice pathways. The SCN under which neurology sits is one of only four SCNs announced. The board have also announced that a National Clinical Director for Chronic Disability and Neurological Conditions will be in post from April 2013.

The announcements signify positive developments for neurology patients and The Migraine Trust will be working closely with The Neurological Alliance as the changes come into place.

Possible genetic link between epilepsy and migraine

The BBC News website ran a story in early January titled ‘Epilepsy and migraine could have a shared genetic link’. It followed research findings published in *Epilepsia* journal indicating that having a strong family history of seizure disorders is associated with a higher chance of having migraine with aura.

We already know that migraine and epilepsy are comorbid, meaning there is an increased chance of the two conditions occurring in the same person or family, however it is not clear why this comorbidity exists.

Researchers at Columbia University Medical Center in New York said, “Epilepsy and migraine are each individually influenced by genetic factors. Our study is the first to confirm a shared genetic susceptibility to epilepsy and migraine in a large population of patients with common forms of epilepsy”.

The researchers added that “the rate of migraine is increased only in people who have close (rather than distant) relatives with epilepsy and only when three or more family members are affected”. Further research will help to improve our understanding of the link between migraine and epilepsy, their diagnosis and treatment.

‘Living with Migraine’ meetings in Hull

The Migraine Trust is most grateful to the Sir James Reckitt Charity who provided funding for a programme of two events in Hull to help people live with migraine.

As we go to print with this issue of Migraine News, the first event has already taken place on Saturday 19 January. The event focused on information about migraine and its management with presentations from consultant neurologists Dr Fayyaz Ahmed and Dr Farooq Maniyar, and headache specialist nurse Vicky Quarshie. Despite the snow and ice affecting much of the UK at the time, the event was well attended and the feedback we received from attendees was very positive.

The second of the events in Hull, on 23 February, is to focus on migraine advocacy and empowering sufferers in areas of patient access to treatment, employment and the welfare benefits system.

The Migraine Trust has organised these events in association with the British Association for the Study of Headache (BASH) and we appreciate their support in organising events such as these.

The Migraine Trust User Group

The Migraine Trust User Group met three times in 2012 at our offices in London. The group is made up of migraine sufferers from across the UK who use their individual skills and personal experience of living with the condition to support our charity. The User Group considers and reviews the charity’s activities to help us ensure that our work meets the needs of the wide cross section of people who suffer from migraine.

The group has given valuable input to a number of consultation responses submitted by the charity last year. If you are interested in finding out more about The Migraine Trust User Group please email Hannah, our Advocacy and Policy Manager at advocacy@migrainetrust.org

Obituary: Dr Frank Clifford Rose

Dr Frank Clifford Rose, Consultant Neurologist at Charing Cross Hospital, London and former Chairman of The Migraine Trust, died on 1 November 2012, aged 86. During his time as our Chairman (1987-1995) he founded, under the Patronage of Princess Margaret, the biennial Migraine Trust meetings which are today known as EHMTIC (European Headache and Migraine Trust International Congress). A full obituary detailing his busy medical career spanning 1949 to 1991 is available on our website at migrainetrust.org/news

Dr Frank Clifford Rose
Link between migraine and risk of heart attack and stroke

Two studies suggesting women who have migraine with aura may be more likely to have problems with their heart and blood vessels, and those on newer contraceptives may be at higher risk for blood clots, will be presented at the American Academy of Neurology’s 65th Annual Meeting in San Diego in March 2013.

The first study found that migraine with aura is a strong contributor to the risk of development of major cardiovascular events such as heart attack and stroke. Study author, Dr Tobias Kurth, said “After high blood pressure, migraine with aura was the second strongest single contributor to risk of heart attacks and strokes. It came ahead of diabetes, current smoking, obesity, and family history of early heart disease”. Dr Kurth cautioned that while people with migraine with aura have an increased risk, it does not mean that everyone with migraine with aura will have a heart attack or stroke.

The second study looked at women with migraine who use hormonal contraceptives and the occurrence of blood clots. Women with migraine with aura were more likely to have experienced blood clot complications with all types of contraceptives than women with migraine without aura. The occurrence of blood clot complications was also higher in women with migraine who took contraceptives than women taking the contraceptives who did not have migraine.

The Migraine Trust’s Susan Haydon was quoted in the Telegraph on 16 January regarding these studies and our trustee Dr Mark Weatherall was quoted in a further Telegraph item on 21 January. Professor Peter Goadsby, a trustee of The Migraine Trust, provided this comment regarding the research: “New research to be presented at the upcoming meeting of the American Academy of Neurology will show a small relationship between migraine with aura and other known risks of heart disease, when present together. The results reinforce the need for migraine patients to have a clear diagnosis, since those without aura have no risk. The results highlight the importance for those with aura to be monitored by their GP for risks for heart problems, such as blood pressure and diabetes.”

Migraine is considered to be insignificant as a risk factor for stroke after the age of 50 compared to more important age-related factors.

Anyone concerned about the risk of cardiovascular events can reduce their risk by not smoking, exercising regularly, eating a healthy diet, and maintaining healthy blood pressure and weight.

The World Health Organisation that recommends women who have migraine with aura should avoid the combined hormonal contraceptive, using instead a progestogen-only form of contraception. It is important to consult your doctor before making any changes to your medication.

For further information, The Migraine Trust has fact sheets ‘Stroke and migraine’ and ‘Migraine and the contraceptive pill’ available from migrainetrust.org/factsheets.

We urgently need your help

To continue our crucial research programme and ensure we fight back against migraine we need your support **now more than ever**

**Please help us by either**

1 Increasing your monthly/annual donation **or**
2 Making a one-off donation

**CALL US TODAY ON 020 7631 6977**
**OR TEXT ‘MIGRAINE’ to 70707 to give £10**

**Together we can beat migraine**

Texts cost £10 plus network charge. The Migraine Trust will receive 100% of your donation
Obtain bill payers permission: Customer Care 0844 847 9800
Registered charity in England & Wales (1081300) and Scotland (SCO42911)
The National Institute for Health and Clinical Excellence (NICE) have published new guidelines on the management of headaches in people over the age of twelve. This may be downloaded at www.NICE.org.uk/CG150. They are based on scientific evidence and are the first headache guidelines that take into account cost effectiveness of treatment as well as clinical effectiveness. Patient representatives were included as full members of the development team (Wendy Thomas, The Migraine Trust’s Chief Executive, was a member of the development team). Before publication The Migraine Trust and other patient groups were asked for their comments.

The guidelines are intended for primary care where most headaches can be safely diagnosed and managed. If specialist advice is necessary the guideline recommends referral to a GP with a special interest in headache or a consultant neurologist with similar interest. NICE also provides supporting information ‘Information for the public’ for headache sufferers which describes what they should expect from their health care provider.

Recommendations are made for diagnosis and treatment of three primary headaches; migraine, tension type headache and cluster headache. Primary headaches are not caused by any other health problem or exogenous substance. They also consider the most common secondary cause of headache, medication overuse. Additionally they highlight special considerations in women with headache including choice of contraception, management during pregnancy, and management of migraine associated with the menstrual period.

Patients may be uncertain when to see their doctor about a headache. In essence if you are concerned seek medical advice. At the first consultation the doctor should ask for a description of the headache and any other symptoms. They will want to ensure the headache is not due to anything serious. NICE have listed features of a headache which should alert health care professionals to look for underlying causes. The doctor may ask for completion of a diary over eight weeks to gather more detailed information about the headache and help them make the diagnosis.

If the GP makes a diagnosis of migraine or tension type headache, further investigation is not usually required. A brain scan is not indicated solely to reassure either the patient or doctor. Adverse effects from scanning include exposure to radiation, and the discovery of radiological changes unrelated to headache that can cause anxiety.

Once the diagnosis is clear it should be explained. Evidence from questionnaire studies showed that patients want empathy, and recognition that headache is a valid medical disorder. This is included in NICE’s recommendations.

Guideline recommendations

Migraine
For immediate (acute) treatment of migraine the guidelines recommend combination therapy with a triptan (glossary) and NSAID (glossary) or paracetamol. In trials this was superior to monotherapy (taking just one drug rather than a combination of drugs) with aspirin, paracetamol, NSAIDs or triptans. If one triptan is ineffective, others may work. Anti-sickness medication can be added. If a patient cannot tolerate oral medication there are other options which include nasal sprays, injections and rectal suppositories.

Although combination therapy was recommended for migraine some patients will have achieved good control with one drug, and may prefer to continue with this. If preventive (prophylactic) medication is required, NICE found that topiramate (glossary) was the most clinically and cost effective medication. However this drug can stop some hormonal contraceptives from working, and can cause congenital abnormalities. Thus it is not always an appropriate choice. NICE recommend propranolol (glossary) as an alternative, and gabapentin (glossary) if contraindicated or ineffective. If patients are taking other migraine prophylaxis which is working such as amitriptyline (glossary), sodium valproate (glossary) or pizotifen (glossary), there is no need to...
stop them. It is worth trying to withdraw migraine prophylaxis after six months, since few people need medication continuously. A course of acupuncture is also recommended as an option, and evidence was found that riboflavin (vitamin B₂) can be effective in preventing migraine.

It must be remembered that NICE guidelines are developed following careful analysis of published clinical trials. Other medications may work well for some patients, but if there are no good quality trials they are less likely to be recommended.

The guideline lists specific recommendations for female migraine sufferers of child bearing age:

1) Combined hormonal contraception should not be used if a patient suffers with aura because there may be an increased risk of stroke.

2) Where migraine associated with the menstrual cycle is particularly severe and not responding to usual treatment, frovatriptan (glossary) or zolmitriptan (glossary) can be taken in anticipation of the migraine, provided the woman can predict the onset of symptoms.

3) In pregnancy, use of any medication should be minimised and it advisable to seek medical advice as soon as possible.

**Tension type headache**

Aspirin, NSAIDs and paracetamol were recommended for acute treatment. Opioids (glossary) should be avoided. No pharmacological prophylactics were recommended, although there was evidence that acupuncture may help. Where there are features of migraine with tension type headache then migraine prophylactics may be tried.

**Medication overuse headache**

This phenomenon is more common in migraine sufferers. If simple pain killers are taken on more than 15 days per month, or triptans (glossary) or opioids (glossary) taken on more than 10 days of the month for three months or more, they may start to cause more headaches. Here the medication must be stopped. NICE recommend this is best done abruptly. It is rarely necessary to go into hospital.

It is not easy for sufferers as the headache will become worse for a few weeks and such patients need support. Afterwards their doctor should re-evaluate the diagnosis, because excess medication may mask other symptoms.

**Cluster headache**

This is a very debilitating condition and most patients need to see a specialist. Oxygen or intranasal / subcutaneous triptans can abort an acute attack. Oral medications of any kind are ineffective. The guidelines recommend verapamil (glossary) for prophylaxis, but this requires heart monitoring. If verapamil does not work a specialist review should be sought.

In summary, headache is a common condition. When symptoms persist or are severe the guideline provides both the healthcare professional and sufferers with useful advice. The guideline committee recognised that more research is needed. Recommendations were made to examine the roles of manual therapies, CBT (cognitive behavioural therapy), exercise, education and self-management programmes.

**Glossary**

**Amitriptyline** A type of medication with multiple use including as an anti-depressant. It can help prevent migraine.

**Ergot** A type of drug used to relieve migraine pain. It is usually avoided because of side effects. An example is ergotamine.

**Frovatriptan** A form of triptan used to prevent migraine pain.

**Gabapentin** A drug used to prevent seizures (fits) in epilepsy. It can help to prevent migraine.

**NSAID** A type of drug that reduces inflammation and pain. An example is ibuprofen.

**Opioids** A type of painkiller used for moderate to severe pain, examples include codeine and dihydrocodeine.

**Pizotifen** A type of medication which can help prevent migraine.

**Propranolol** A drug used to treat high blood pressure and heart conditions. It can prevent migraine.

**Sodium valproate** A drug used to prevent seizures (fits) in epilepsy. It can help to prevent migraine.

**Topiramate** A drug used to prevent seizures (fits) in epilepsy. It can help to prevent migraine.

**Triptan** A type of drug used to relieve migraine pain. Examples include almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan and zolmitriptan.

**Verapamil** A drug used to treat high blood pressure and heart conditions. It can prevent cluster headache.

**Zolmitriptan** A form of triptan used to prevent migraine pain.
European Headache and Migraine Trust International Congress

The 3rd European Headache and Migraine Trust International Congress (EHMTIC) was held on 20-23 September 2012 in London. EHMTIC is an opportunity for headache doctors, researchers and nurses from around the world to present, and learn about, the latest headache research and how to treat different headache types.

This year, The Congress included the launch of guidance from the National Institute for Health and Clinical Excellence (NICE) on the management of the three most common headaches with which people present to their General Practitioners (GPs): migraine, tension-type headache and cluster headache. EHMTIC offered presentations on basic science and courses aimed at GPs and other clinical staff. On 23 September a programme was offered to the lay public with an interest in migraine and headache.

EHMTIC started on Thursday 20 with three courses: ‘Getting to grips with headache’ aimed at GPs, an interactive session called ‘How to manage migraine’ aimed at clinical staff, and ‘Novel techniques and developments in migraine research’ for basic scientists.

The day continued with the opening ceremony during which The Migraine Trust’s Chair of Trustees, Ian Watmore, spoke about his experience of living with migraine. The Macdonald Critchley lecture was given by Dr Tobias Kurth from the University of Bordeaux Segalen, France, on ‘The Epidemiology of Migraine Genetics’. Dr Macdonald Critchley, 1900-97, was influential throughout the neurological world and was one of the founders of The Migraine Trust. The day finished with a satellite symposium on cluster headache.

Friday 21 September started with a joint session between EHMTIC and the International Association for the Study of Pain on the relevance of pain imaging studies for understanding migraine, and analgesic drug development, followed by a poster session on genes and the environment, epidemiology and paediatric (childhood) headaches. In the afternoon another poster session covered primary headaches such as tension-type headache and trigeminal autonomic cephalalgias often called TACs (such as cluster headache). Following a session on childhood headaches, The Migraine Trust lecture on the neurobiology of migraine pain was delivered by Dr Karl Messlinger of the University of Erlangen-Nurnberg, Germany. The day finished with a satellite symposium entitled ‘Single pulse transcranial magnetic stimulation sTMS: a novel, non-invasive, neurostimulation device for acute treatment of migraine.’

Saturday 22 started with a poster session on the basic science of migraine, followed by the Jes Olesen lecture entitled ‘Headache research: where are we heading?’ and new scientist’s lectures. This was followed in the afternoon by two poster sessions: clinical experimental science in migraine, then diagnostics and other clinical aspects of headache. Parallel sessions included the rehabilitation of chronic headache and a meeting of the International Forum of Headache Nurses. A joint meeting was held of the International Headache Society’s Primary Care Group with the British Association for the Study of Headache (BASH) General Practitioners with a Special Interest in Headache group, on moving the primary care agenda forward. The day finished with a lecture on depression and the risk of migraine transforming from episodic to chronic migraine, followed by a satellite symposium on triptans.

Sunday 23 included a session on secondary headaches (where headache is a symptom of an underlying condition), acute and preventative migraine therapy and awards. In the afternoon the EHMTIC public programme took place, with presentation of material from the main congress, for members of the public living with migraine and other primary headaches or other lay people with an interest in the subject.

We are fortunate to have received accounts of EHMTIC sessions from some of the doctors who attended.
Reports from the EHMTIC 2012 London

Headache: A ‘trivial’ disorder affecting adults and children

Dr Anna P Andreou

In research terms, headache has moved on from being regarded as a trivial and neglected disorder to being respected and acknowledged. The 2012 European Headache and Migraine Trust International Congress (EHMTIC) in London gave the opportunity to hundreds of scientists to present their data on all areas of headache research, from experimental research, genetics, epidemiological and costs studies to new treatments and optimised care. Headache can affect the performance of any sufferer. Preliminary data from the 2012 EHMTIC, only weeks after the London Olympics, demonstrated that 57% of the UK elite athletes who completed a relevant questionnaire reported that headaches limited their optimal performance and 41% had no effective method of treating their attacks. Results from this study, by Hall and colleagues, suggest that UK athletes could have performed better in the London Olympics if headache were not a significant factor limiting their performance.

Headache does not only affect adults but it also significantly affects children. Migraine without aura could be considered the most frequent form of primary headache in children, associated with many known comorbidities. Studies presented at the EHMTIC demonstrated that one in 30 children has a headache problem which has a significant impact on the child and their family. Children with chronic symptoms of tension-type headache have increased sensitivity to pressure-like stimuli compared to children who were not headache sufferers, indicating altered pain perception in these children. However, childhood headache remains an under recognised, under treated and a challenging problem for primary care consultants. Once a diagnosis is achieved, treatment strategies for childhood headache should involve a multi-faceted approach, including treatment strategies for acute attacks and prevention, lifestyle management such as diet, exercise and sleep, psychosocial factors and trigger identification and avoidance. The risk of headache worsening in children due to medication overuse was also highlighted during the EHMTIC, as 20% of children suffering from daily headache are at risk of developing medication overuse headache.

Despite scientific and clinical achievements, millions of headache patients are still suffering from severe headaches, significant disability and limited access to specific and proper headache treatment. Results presented at the 2012 EHMTIC in London offer significant insights as to where the headache research field should be moving for the development of effective headache care.

One in 30 children has a headache problem which has a significant effect on their life
Recent advances in headache genetics

Dr Anna P Andreou

Genetic factors make a strong contribution to the development of primary headaches, such as migraine and cluster headache. While identifying specific genes for the rare familial hemiplegic migraine form has advanced well, the contribution of genetic factors to more common forms of migraine in the population remains challenging. Genetic research around the molecular mechanisms involved in different types of headaches, particularly in migraine without aura, is significantly increasing and research advances have been presented during the 2012 EHMTIC.

Genome-wide association studies (GWAs) have been applied to identify genetic variants associated with a higher risk of developing migraine. A big GWA study by de Vries and colleagues, which included analysing genome-wide association data of over 2300 people with migraine without aura from large European headache clinics, identified alterations in or near some genes (the MEF2D, PHACTR1, ASTN2, TGFB2, TRPM8 and LRP1 genes). The discovery of the involvement of mutations affecting these genes is surely a significant advancement in the study of the genetics of migraine without aura; however, the biological mechanisms with which such mutations may interfere in migraine pathophysiology remains unclear.

The TGFB2 gene may be responsible for cell growth factors, the MEF2D gene is involved in muscle and neuronal cell differentiation, the PHACTR1 is involved in neuronal function and angiogenesis (growth of new blood vessels), while the TGFB2 gene is also involved in neuronal function. The LRP1 gene is responsible for the cholesterol entrance in neurons and the TRPM8 gene is responsible for the detection of cold. GWAs outline future directions in migraine genetics; however more research is required to identify the involvement of such mutation in biological reasonable mechanisms for the development of migraine.

Candidate gene association studies in migraine patients further demonstrated a potential role of mutations in the BDNF gene, which is closely involved in the pathophysiology of mood disorders and pain processing, in the development of migraine chronication. Such mutations may also play a role in the high comorbidity between migraine and mood disorders. In a different study, Quintas and colleagues identified mutations in the GABA genes encoding for receptor subunits of the neurotransmitter GABA that are associated with migraine susceptibility. Additionally, given that these genes are expressed by the X-chromosome, mutations in these genes may shed some light on the female prevalence of migraine.

Although no further studies identified single genes that may play a role in other types of headache beyond migraine, a study by Southgate and colleagues demonstrated preliminary data on the search of genetic factors in cluster headache patients, for which a genetic predisposition has been long debated.

Diagnostics and other clinical aspects of headache

Miss Margarita Oliveira

The EHMTIC 2012 included a wide variety of studies presented by researchers and/or clinicians on the diagnostics and clinical aspects of headache.

The study about the new Auto-Injector (Alsuma) for the acute treatment of the migraine attack, which consists in the administration of a subcutaneous (placed under the skin) dose of sumatriptan, showed that the Auto-Injector was safe and well tolerated by patients. Moreover, the majority of patients reported the Auto-Injector was easy to use.

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Headaches, as well as associated migraine symptoms, are present early during the aura phase of the migraine attack in the majority of patients

Another interesting study aimed to determine the timing of headache and other migraine symptoms relative to aura in migraine patients. The results of the study showed that headaches, as well as associated migraine symptoms (nausea, photophobia and phonophobia), are
Research

present early during the aura phase of the migraine attack in the majority of patients. Ultimately, the results indicate that multiple anatomical and physiological mechanisms may be occurring simultaneously and in parallel during a migraine attack.

Addressed in another study was also the clinical characterisation of ‘visual snow’, described as persistent, dynamic, black and white tiny dots in the entire visual field. The ‘visual snow’ is almost always associated with additional visual symptoms, namely excessive floaters, persistent after-images, ‘hard time seeing at night’, ‘little cells that travel on a wiggly path’, ‘moving objects leave trails’, ‘swirls, clouds or waves with eyes closed’, and bright flashes. The results of the study indicated that ‘visual snow’ is a unique clinical syndrome and the visual symptoms are distinct from migraine with aura. Moreover, the high prevalence of history of migraine (with aura) points to a susceptibility for visual snow in patients with migraine.

Another study presented at the EHMTIC aimed to study the comorbidity between migraine and hypothyroidism. Comorbidity refers to greater than coincidental association of separate conditions and the diagnostic criteria of ‘headache attributed to hypothyroidism’ requires the headache to resolve within two months after effective treatment of hypothyroidism. Interestingly, the results of this study showed a high prevalence of hypothyroidism in migraine, significantly higher than in the general population.

A research group presented a study focusing on exercise, affective (relating to moods, feelings and attitudes) response and migraine frequency. This study is a case report of a young woman with migraine going through a moderate aerobic exercise training protocol (30 minutes treadmill exercise performed three times a week, for four weeks). Exercise is known to elicit affective (emotional) response and the authors measured affective response by using a feelings scale at first and last sessions. The results showed a negative emotional response with exercise at the beginning of the study. However, this was reversed after the exercise training protocol, besides reducing the frequency of migraine attacks from 13 to nine attacks per month.

Furthermore, a new instrument for measuring pain and quality of life, DoloTest, was presented. The DoloTest measures eight different domains (pain, problems with light physical activities, problems with more strenuous physical activities, problems doing your job, reduced energy and strength, low spirit, reduced social life and sleeping problems) and provides a graphic picture of a patient’s pain, as well as a numeric score. The aim of the ongoing study was to apply DoloTest in headache patients before, during and after psychological treatment. The authors state that the DoloTest may be a valuable tool to measure the effect of psychological treatment.

In summary, the latest studies presented at the EHMTIC 2012 proved to be very important and useful, providing a better knowledge of the complex pathophysiology of headaches and new exciting treatment options, which in turn, will improve the healthcare system for headache sufferers.

Neurostimulation devices in headache treatment

Dr Jan Hoffmann and Dr Weera Supronsinchai

Neurostimulation devices have been of increasing interest for the treatment of primary headaches in recent years. After initial experiences with deep brain stimulation for the treatment of refractory cluster headache, which has been hampered by severe side effects, several new minimally invasive and non-invasive devices are being tested for migraine and other primary headaches.

Results from initial experiences and recent clinical trials have been presented at the 2012 EHMTIC.

1. Regarding the minimally invasive neurostimulation devices, Prof Schoenen from the Headache Center in Liège, Belgium, presented results from a clinical trial testing the efficacy of sphenopalatine ganglion (part of the parasympathetic nervous system responsible for activities that occur when the body is at rest) stimulation using the ATI® implantable microstimulator which is implanted into the pterygopalatine fossa (a small bony cavity shaped roughly like a funnel near the base of the skull).
to disrupt the parasympathetic reflex. In this system stimulation is initiated using a portable remote control unit. The results show that the 27 patients who took part reported that pain relief could be achieved in 67% of treated headache attacks. However, the study has a small sample and patients experienced a transient numbness at the stimulation site, affecting the blinded design of the study, so study participants knew whether they had the real or the ‘dummy’ stimulator.

2. Non-invasive devices presented at EHMTIC followed different stimulation methods. Single pulse transcranial magnetic stimulation (sTMS) has recently been tested in a clinical trial and the results suggested a weak but significant effect for the acute treatment of migraine with aura. Results from a post market study with the portable SpringTMS™ device have been presented at this year’s conference. The study involved 37 patients who recorded a total of 777 migraine attacks. A reduction of migraine pain was reported by 73% of patients and a reduction of migraine associated symptoms by 63% with no adverse events reported. The results suggest a possible efficacy of the device for the acute treatment of migraine. However, sample sizes were small and headache reporting was controversial since no objective reporting in headache diaries, as is standard for clinical trials, was available. Therefore further placebo-controlled studies with larger sample sizes and objective symptom recording have to be conducted to clarify whether TMS is effective in the treatment of acute migraine attacks.

Furthermore, initial data with the Gammacore® device for transcutaneous vagus nerve stimulation (tvNS) for the treatment for several types of primary headache was presented. While the initial data on migraine without aura (including patients with medication overuse headache) have been rather disappointing, Nesbitt et al showed results on 14 cluster headache patients (seven with episodic cluster headache, seven with chronic cluster headache) treated over 14 weeks which showed a subjective improvement of 60% in 13 patients.

However, as in the trials with the previously mentioned devices, sample sizes were very small and stimulation was not blinded as patients felt the stimulation. In addition, the Gammacore® device produced significant side effects ranging from paresthesias (pins and needles) to pain during stimulation leading to high dropout rates. Despite the fact that it is marketed as a vagus nerve stimulation device, stimulation is unspecific affecting sympathetic and parasympathetic nerves. Taken together the results show that larger trials are needed to clarify if the Gammacore® device may prove useful for the treatment of primary headaches, especially cluster headache and other trigeminal autonomic cephalalgias.

Finally, data from a multi-center, double-blind, randomised, sham-controlled trial including 67 patients analysing the efficacy of a transcutaneous supraorbital nerve stimulator (tSNS), the Cefaly® device, for the prophylactic treatment of migraine were presented. Stimulation was performed for 20 minutes on a daily basis for three months. The results show a reduction of monthly migraine days and drug intake while no adverse events were observed. Therefore the results indicate that tSNS may offer an effective prophylactic migraine treatment. However, larger trials are needed to clarify its potential efficacy.

Many different types of neurostimulation are currently being tested for the acute and prophylactic treatment of primary headaches. However, existing trials are small and frequently hampered by severe methodological shortcomings. A challenge for future trials will be the achievement of true sham-controlled trials since almost all devices currently available and the stimulation protocols used induce paresthesias or even pain during stimulation thereby leading to a certain extent of unblinding of the treated individual. With these problems solved, neurostimulation devices might finally offer a migraine-specific preventive therapy.

Several new minimally invasive and non-invasive devices are being tested for migraine and other primary headaches

Clinical research in migraine pathophysiology

Dr Christoph Schankin

New data in respect of clinical description, testing, brain imaging and treatment were presented during the 2012 EHMTIC. Findings for episodic migraine (occasional headache) and chronic migraine (headache on more than 15 days per month) are presented here separately, due to the practical relevance.

Headache on less than 15 days per month (episodic migraine)

Clinical description

Seck and colleagues described a series of 100 patients with migraine in Africa (Senegal). They showed that migraine and its clinical course is similar to other continents including improvement during pregnancy. However, about 60% have never seen a doctor for the headache, which indicates that it is still neglected although affecting quality of life significantly.

Hougaard and colleagues tried to trigger headaches in patients who reported that their headaches are typically triggered by either light stimulation or strenuous exercise. Only in a minority of patients could headache be triggered by light (22%) or exercise (33%). This is an important study since it shows that the time prior to a headache attack, the so-called premonitory phase, needs to be studied in more detail when talking about triggers, particularly since certain
situations prior to a headache could be interpreted either as triggers, i.e. causing the headache, or as premonitory symptoms, i.e. the first symptoms of the attack.

In a different study, Antonova and colleagues were able to induce migraine-like headache immediately in migraine patients by infusion of prostaglandin E2 (PGE2). PGE2 is generated by cyclooxygenase (COX), the enzyme that is inhibited by common analgesics, such as aspirin or ibuprofen. This indicates that PGE2 is involved in headache generation. It was further demonstrated that inhibition of one specific PGE2-receptor (EP4) was not able to stop this activation indicating that the receptors involved might be complex.

Koppen and colleagues tested the vestibular system (which contributes to balance and the sense of spacial orientation) of migraine patients in comparison to a group of people without migraine and another group of patients with familial hemiplegic migraine (FHM), a rare subtype of migraine with aura. They could only demonstrate differences between the FHM patients and both of the other two groups (migraine patients and those without migraine). There were no differences between the migraine patients and the group without migraine showing that FHM differs from episodic migraine with aura in respect of the vestibular system.

A Japanese study by Takeshima and colleagues analysed headache frequency and body mass index in a series of 2662 headache sufferers. They found a higher frequency of headache days in patients with a BMI above 25 (classified as overweight, obese, and morbid obese) with 8, 10, and 13 headache days per month and a higher frequency of chronic headaches indicating that obesity is an important factor contributing to headache chronification.

Testing
Calcitonin gene related peptide (CGRP) is thought to be an important neuronal peptide for migraine pathophysiology. When capsaicin (the hot chilli substance) is applied to the facial skin, it results in vasodilation (widening of blood vessels), which is mediated by CGRP and can be measured. Ibrahim and colleagues have tested this vasodilation response in women prior to and during the menstrual period and found an increased response during the menstrual period indicating a mechanism by a fall in oestrogen level that occurs naturally at this time. This might be important for the understanding of the higher frequency of migraine in young women.

Brain imaging
In an important study by Maniyar and colleagues, migraine attacks were triggered in patients who typically have symptoms prior to the beginning of their headaches (premonitory phase). These patients also showed the same premonitory symptoms prior to the triggered attack. Brain scans during this phase depict activation in the hypothalamus and midbrain. This indicates a beginning of the headache in these brain areas – but not in the meninges (membranes covering the brain and spinal cord) or perimeningeal blood vessels.

Treatment
Lizunou and colleagues analysed the effect of a surgical closure of a heart defect (atrial septum defect) on migraine in 75 children. Only eight children had migraine prior to treatment. Two experienced complete resolution and six some improvement. Interestingly, another six patients developed new-onset headache in the week after treatment. The long term effects of this treatment were not shown and thus, this treatment cannot be recommended at the moment for headache alone.

Sharma and colleagues reported on yoga therapy in the treatment of chronic migraine. They found that yoga therapy was able to reduce headache frequency, pain intensity, pain duration, depression, and improve functional status indicating some usefulness of yoga therapy for this debilitating medical condition.

Finally, a Phase 1 study of a possible new medication, the CGRP-receptor antagonist BMS-927711 in two groups of eight volunteers without migraine demonstrated safety of this substance and its efficacy in migraine patients remains now to be established.

Headache on more than 15 days per month (chronic migraine, CM)

Clinical description
Dodick and colleagues presented data on 1384 patients with chronic migraine from the PREAMPT Botox trials. During the greater proportion (90%) of days in the study, patients had at least moderate headaches. Sensitivity to light and sound were also extremely common (about 80% of days). Furthermore, these headaches usually worsened with physical activity and thus resulted in avoidance of routine activity, demonstrating the significant impact on patients’ daily life.

In a different study by Gonzales and colleagues, it was shown that anxiety, mood disorders and disability are more frequent in patients with chronic
migraine and cluster headache than in the episodic forms, supporting the necessity of multidisciplinary treatment of these disorders.

Testing
Cernuda-Morollon and colleagues demonstrated an elevation of calcitonin gene-related peptide (CGRP) in the blood of patients with chronic migraine. This indicates a permanent activation of the so-called trigemino-vascular system pointing to continuous or recurrent migraine attacks. Similarly, Coppola and colleagues showed that the electrophysiological pattern in patients with chronic migraine corresponds to the finding in acute headache attacks in episodic migraine.

Relevance of pain imaging studies for understanding migraine

Dr BCittadini

During the European Headache and Migraine Trust International Congress (EHMTIC) a joint session was held with the International Association for the Study of Pain (IASP) to mark the IASP global year against headache which finished in October 2012. Professor Irene Tracey, Nuffield Professor, Anaesthetic Science and Director, Oxford Centre for FMRI (functional magnetic resonance imaging) of Brain, UK presented a summary showing how studies of brain imaging or scans help our understanding of the complexity of the experience of pain, including migraine.

With the advent of neuroimaging or brain scans, our understanding of pain perception in humans has increased significantly, and has led to an increased awareness of how different factors – including cognition, emotion, mood, context and injury – can influence pain perception. Data from brain scan studies give information about the brain regions most commonly found to be active during pain. One of the key players that underpins the ability to change pain intensity is a brain pathway known as the brainstem’s descending pain modulatory system (DPMS) which includes a brain area called the periaqueductal grey or PAG.

The results of the studies showed the relevance of the PAG in migraineurs, with strong connectivity between the PAG and several other brain regions that are within the pain and sensory processing pathways. An increase in migraine attacks was found to be associated with a decrease in connectivity between the PAG and brain regions with a role in pain modulation (how the brain adjusts or regulates our experience of pain). The findings support the hypothesis that in people with migraine there is an impairment of the brain’s descending pain modulatory circuits, which is likely to lead to a loss of pain inhibition, and hyperexcitability in those brain areas involved in pain perception.

Pain is a multidimensional and highly subjective experience and factors such as attention, mood, cognitive state, personality and expectations, are important in the experience of pain. A study showed that when people are anxious and pain-attentive, the descending connectivity to pain modulatory brain areas is weaker. In addition, whether a sensation is perceived as painful does not depend only on sensory input but also on the significance of the stimulus.

A recent model of migraine suggests a dysfunctional pain network. This model, known as the ‘neuralimbic pathway’ is intended to encompass all of the known features of this complex disorder. The limbic system is a complex set of brain structures which appear to support a variety of functions including emotion and memory. A neuralimbic model of migraine may help to bridge a gap in our understanding of migraine attacks:
dysfunction in between migraine attacks, the progression from episodic to chronic migraine and the common comorbidities with other disorders (such as fibromyalgia, irritable bowel syndrome and mood and anxiety disorders) which may also be considered neuralimbic.

Expectation is an important factor that influences the experience of pain and a study from Professor Irene Tracey’s group confirmed how different expectations can modulate the outcome of treatment, in
Expectation is an important factor that influences the experience of pain

This case a potent opioid treatment (remifentanil). In fact, a positive expectancy of treatment doubled the analgesic benefit of remifentanil. In contrast, negative expectancy of treatment abolished remifentanil analgesia. Positive expectancy of treatment was associated with activity in the brain’s endogenous pain modulatory system, whilst negative expectancy of treatment was associated with activity in another brain area, the hippocampus. This information is very relevant in the clinic where people with a long history of chronic pain and failed drugs may develop anxiety and negative expectations.

Migraine is twice as common in females as in males but the underlying mechanism is still poorly understood. A brain imaging study showed a substantial difference in brain activation in response to a noxious stimulus in female versus male migraineurs in the period between attacks. The data therefore suggest a differential effect of the disease in female versus male migraineurs. This study is important as it highlights the importance of developing studies where sex is taken into account. Finally a study of female migraineurs with dysmenorrhea (painful periods) showed increased sensitivity to pain throughout the menstrual cycle and suggests that dysmenorrhea is associated with central nervous system changes that persist beyond the time of menstruation.

In summary, functional imaging or scanning of the human brain has improved our understanding of brain function in general and specifically for pain disorders including migraine. This, together with other information including genetics, environmental factors, lifestyle, cognitive factors, mood and personality, can be used in the discovery of new treatments for pain.
Dr Anna Andreou awarded The Migraine Trust Fellowship 2012

The Migraine Trust’s commitment to research has led to the development of The Migraine Trust Fellowship which aims to fund and promote research towards a greater understanding of migraine, its underlying mechanisms and improved treatment. In supporting researchers, The Migraine Trust aims to promote research in the headache field, to improve the teaching of headache disorders in medical academic institutions (which for UK institutions has been minimal) and to increase awareness of the impact of migraine.

Dr Anna Andreou has been awarded The Migraine Trust Fellowship for 2012. She completed her PhD in Neurology at the Institute of Neurology, University College London, funded by a Migraine Trust Scholarship. During her PhD she investigated, along with Prof Peter Goadsby, the therapeutic potential of new pharmacological migraine treatments. Anna decided to pursue a career in headache research because of the disappointment she felt, being a migraine sufferer herself, that little is known about the cause of migraine and also that its treatment is unsatisfactory. Following her PhD, Anna moved to the University of California San Francisco, where she focused her research on investigation of the brain networks involved in the physiology underlying migraine and the effectiveness of neurostimulation in the treatment of headaches.

Since completing her PhD, Anna has received a number of awards including the Thomas E Hettler Migraine Research Award from the American Headache Society and the Migraine Research Foundation, and the 2012 Early Research Career Grant by the International Association for the Study of Pain. She is a co-recipient of the Enrico Greppi Award in 2010, and she has twice received the European Headache and Migraine Trust ‘New Scientist Lecture’ and the American Headache Society ‘Frontiers in Headache Research’ Scholarship Awards. She is also the chair of the Trainees and Residents special interest group of the International Headache Society, which aims to promote the teaching and research activities of scientific and clinical trainees in the headache field.

Currently, having been awarded the Migraine Trust Fellowship, Anna is a headache research fellow at Imperial College London. Her research is focused on looking at the brain mechanisms that trigger head pain and neurological dysfunctions during migraine attacks. With her fellowship, Anna aims to investigate how dysfunction of a brain area called the hypothalamus may lead to activation of the brain’s pain pathway and the generation of a migraine attack. Although it has been assumed for some time now that an abnormal function of the hypothalamus might be a potential trigger of a migraine attack, it was only recently shown to be activated in the early phase of a migraine attack. How hypothalamic dysfunction may induce the symptoms seen in migraine patients, such as headache, aura, sensitivity to light and sound is the focus of Anna’s research. She aims to investigate this by studying the neural networks of the hypothalamic brain area together with other brain areas involved in the development of migraine aura, pain and light sensitivity.

Anna hopes that her research will prove beneficial in clarifying the sequence of events at the start of a migraine attack, while outcomes from this study may also have some translational impact on understanding the underlying physiology of cluster headache, which is another severe primary headache disorder. It is already known that deep brain stimulation at a region of the hypothalamus is effective in reducing the frequency of cluster headache attacks. Most importantly, Anna expects that her studies not only will benefit patients by increasing understanding of the mechanism of migraine, but also will lead to an almost untapped opportunity to pursue new migraine specific therapeutic developments that will benefit migraine patients in the long term.
If you would like to fundraise for us please contact our Fundraising team on telephone 020 7631 6977, email fundraising@migrainetrust.org or visit our website at migrainetrust.org/fundraising.

**London Marathon**

Our next big fundraising event will be the Virgin London Marathon on Sunday 21 April. We have an amazing 11 supporters running for us this year, so we would like to say a big thank you to our 2013 team. You can show your support by sponsoring one of our marathon team or any of our fundraisers by visiting justgiving.com/migrainetrust.

**Open gardens**

Once again in summer 2012 kind supporters opened their gardens and raised money for The Migraine Trust. Valda Walker opened her garden again for The Migraine Trust over two days in March and raised £532. Kathy Caddy opened her garden for the first time in June and even managed to pick a sunny day. She raised £274 over two days. We would like to say a big thank you to both Valda and Kathy. If you would like to open your garden and raise money for The Migraine Trust please do get in touch.

**FSI Challenge**

In June mother and daughter team Carol and Alice went to the picturesque Peak District and took part in the Foundation for Social Improvement (FSI) 10K Challenge. Carol and Alice raised over £1,000 for The Migraine Trust. Alice said “Suffering with migraine has had a huge impact on my life, often stopping me from doing normal activities and putting life on hold at times. Please sponsor me to complete the run and help The Migraine Trust continue with the exceptional work they do.”

Congratulations and thank you to both of them for taking on this challenge.

**Miles for migraine**

You may have spent your summer holiday in the sun or relaxing in the countryside, but supporter John Marshall spent his summer walking, cycling, climbing and kayaking 750 miles from John o’Groats to the Humber Bridge raising money for The Migraine Trust as he went. And after a hard day John didn’t find a nice hotel to sleep in overnight – he set up his tent wherever he happened to be! John told us “As a chronic migraine sufferer I want to use this opportunity to raise money for The Migraine Trust” and he raised a wonderful £194. You can still sponsor John by texting MIGR47 £5 to 70070.

**British 10K powered by Nike+**

On a rainy Sunday in July our team of 15 runners took to the streets to raise money for us. Jen Bolton, Emma Budgen, Jess Fletcher, Dave Schneider, Dinesh Luchmun, Harriet Morris-Sloane, Tom Hayman, Simon Hayman, Jade Bennett, Denise Sloane and ‘Team Tower’, a team of printers and designers from our friends at Tower Printing, took to the streets and raised over £4,000. Thank you to everyone who took part for all the hard work you put into your training and fundraising.

If you would like to follow in their footsteps we are now recruiting our 2013 team. This year the British 10K will be on Sunday 14 July and we are hoping for sunshine. Our places are free, but runners must pledge to raise £200 in sponsorship for The Migraine Trust. Email fundraising@migrainetrust.org for more information and an application form or visit our website.

**Mablethorpe Half Marathon**

Supporter of five years and hemiplegic migraine sufferer Jennifer took on the Mablethorpe Half Marathon in October for The Migraine Trust raising £290 in sponsorship to help us with the invaluable work we do. We would like to thank Jennifer for her continued support through both her regular giving and fundraising.

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_If you would like to follow our fundraising news on Twitter, please follow us @MigraineNews_
Abbie gets muddy for migraine

In November, brave supporter Abbie braced the cold night air and ran, crawled, leapt and sloshed about to raise money for The Migraine Trust. Abbie took part in the Men’s Health Survival Race at Battersea Power Station and finished the 5km night time obstacle course in 51 minutes, raising a fantastic £115 for The Migraine Trust.

Thank you Abbie for taking on this cold, muddy yet fun challenge for The Migraine Trust!

You can show your support by sponsoring one of our marathon team or any of our fundraisers

Calling all cyclists!

Over the years we have had places in various running events from 5km to Marathons. This year for the first time we are looking for cyclists to take on some amazing challenges for The Migraine Trust! We have three different events to choose from: London 2 Cambridge Moonride, London 2 Brighton Moonride and a spooky Halloween Moonride. These events are a tough 100km cycle under the moonlight, through picturesque countryside or around the city sites. Each event has a registration fee of £49 and fundraisers have a fundraising target of £300.

If you are interested in take part visit migrainetrust.org/fundraising/cycling to find out more and register.

Remember A Charity

In September we got involved with Remember A Charity’s annual awareness week to promote leaving a gift to charity in your Will. The face of the campaign was weatherman, Michael Fish. Michael said “UK charities rely heavily on gifts in Wills. So during Remember A Charity Week, we’re calling on people to think about the good causes they value and make room for a charity in their Will, after they have looked after their family and friends.”

At The Migraine Trust, like many other UK charities, without the generosity of individuals who leave a gift to us in their Will we simply would not be here to provide information and support to people with migraine, fund research or even produce Migraine News. We hope that when the time does come, you will take the time to remember the work we do for all those who suffer from migraine.

Easy fundraising

Do you shop online? Did you know that every time you buy something you could be raising money for The Migraine Trust at no extra cost to you? Over 2000 well known retailers including Amazon, Waitrose, House of Fraser, and many more, will donate a percentage of what you spend to The Migraine Trust when you shop with them via easyfundraising.

Visit easyfundraising.org.uk/migrainetrust
**Forthcoming events:** If you would like further information about any of the events listed below, please call 020 7631 6977, email events@migrainertrust.org or visit our website migrainertrust.org/events

**MARCH**

11-17th: Brain Awareness Week, International
A global campaign to increase public awareness of the progress and benefits of brain research.
Visit [dana.org/brainweek](http://dana.org/brainweek)

12th: Meeting in Parliament, London
Next All-Party Parliamentary Group on Primary Headache Disorders (APPGPHD) meeting in the House of Commons

17th: Rome Marathon, Italy
We have three brave supporters running for us in Rome this year.
Visit [justgiving.com/migrainertrust](http://justgiving.com/migrainertrust) to sponsor them

**APRIL**

20th: Medicine and Me – Living with Migraine, London
A migraine information event organised by the Royal Society of Medicine in association with The Migraine Trust

21st: Virgin London Marathon, Central London
Sponsor a Migraine Trust marathon runner at [justgiving.com/migrainertrust](http://justgiving.com/migrainertrust)

**MAY**

10th: London 2 Cambridge Moonride
You don’t have to be a runner to take on a challenge for The Migraine Trust. Contact The Migraine Trust if you’re interested in getting on your bike and raising funds

**JUNE**

22nd: Trans Pennine Challenge, Manchester to Sheffield
Whether you walk or run, tackle 50km or 100km, redefine your goals in 2013 and take on this challenge in the magnificent Peak District

**JULY**

14th: The British 10K powered by Nike+, London
You can take part in this popular event and fundraise for charity at the same time. Contact The Migraine Trust to apply
The Migraine Trust is the health and medical research charity for migraine in the United Kingdom.

The Migraine Trust is committed to supporting all those affected by migraine and disabling headache. We seek to raise awareness of migraine and headache as a serious public health problem. The Migraine Trust funds and promotes research into migraine and disabling headache for the purposes of better understanding, improved diagnosis and treatment and, ultimately, to find a cure for these debilitating conditions.

Information and Enquiry Service: we can help with questions you may have about migraine, other headaches and their management. All our information is based on the best available evidence.

Telephone: 020 7631 6975 please leave a message if necessary and we will get back to you or Email: info@migrainetrust.org

Advocacy Service: We can provide advocacy support to empower migraine sufferers to assert their rights and claim their entitlements in the areas of healthcare, employment and education. (See website for further details and resources).

Telephone: 020 7631 6973 Email: advocacy@migrainetrust.org

Events: throughout the year we organise a variety of educational events around the UK that cater for both health professionals and the public. (See website for details of upcoming events).

Website: information about migraine and headache is available at our website including downloadable fact sheets and packs. You can also subscribe to The Migraine Trust’s ebulletin.

The Migraine Trust is a registered charity funded entirely by voluntary donations from individuals, charitable trusts and corporate supporters. Without your support we would be unable to continue our work. Please give your support by making a donation or become a regular supporter and receive our journal Migraine News.

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