A Life Under Damocles’ Sword, Part 2
Migraine Trust Supporter Brett Gooden, MD, shares his story

Migraine Trust Research Update

Transcranial Magnetic Stimulation (TMS) for Migraine
LETTER FROM THE CHIEF EXECUTIVE


We enter 2014 with great excitement and anticipation of what the year might hold. Since the beginning of the year we have made significant advances in all areas of our work and I really believe that we are at the beginning of a period of progress in both the understanding and treatment of migraine.

The Migraine Trust is funding important research which is delivering valuable new knowledge of what is actually going on in the brain during an attack. I am delighted to be able to tell you that we will also be launching a further Research Fellowship later this year, which will effectively double our research capacity – and our programme is of course the only dedicated migraine research currently being undertaken in the UK.

We are working on plans to expand our advocacy service, which has been running for almost two years. Building on the successes of the service, and the increasing demand to support those under threat of losing their job because of migraine, we want to ensure that more sufferers have access to this support at the earliest opportunity.

We will be running five Managing Your Migraine events around the UK this year, meeting migraine sufferers in person, with more planned in 2015.

And finally, we are working on the development of our information service to make sure that we continue to be the most vital, up-to-date resource available to migraine sufferers.

All of this progress, and everything you read in this edition of Migraine News, is a direct result of the support we receive from the migraine community. We receive no statutory support at all – 100% of our income is from voluntary contributions from individuals and organisations. We can achieve nothing without your help.

I hope that we have been able to help you and your family in some way. If so, I would urge you to support us today as best you can. Not just for your own benefit – but so that we may continue to be here for the next generation of migraine sufferers and improve migraine treatment for all in the future.

Best wishes and good health,

Wendy Thomas
Chief Executive
Headache Quality Standards Published

The National Institute for Health and Care Excellence (NICE) published the Quality Standards for headache in young people and adults at the end of August 2013. The quality standards refer to all primary headache disorders including migraine and apply to the NHS in England and Wales. NICE quality standards are a set of prioritised statements that ‘aim to drive measurable quality improvements within a particular area of health or social care’. They set out what high quality standards look like rather than just a minimum standard. The quality standards are based on existing evidence-based guidance e.g. NICE clinical guidelines, and are developed independently in collaboration with health professionals, patients and patient organisations.

The Migraine Trust’s Chief Executive Wendy Thomas represented migraine sufferers on the Headache Quality Standards committee as a lay member. Wendy worked alongside leading health professionals with a special interest in headache and with NICE to develop the standards. Prior to today’s publication, the public and stakeholders had the opportunity to give feedback to NICE during the consultation period.

The NICE Quality Standards for headache will enable:
- **Health Professionals** to make informed decisions about the best treatment and care for headache and migraine sufferers.
- **Headache and migraine patients** to find information about the quality of services and care they can expect.
- **Service providers** to examine the quality of the service they deliver and assess improvements.
- **Commissioners** to commission only high quality and cost effective services. Quality Standards will inform payment mechanisms and incentive schemes under the new commissioning system.

To read more about the Headache Quality Standards visit [www.migrainetrust.org/news](http://www.migrainetrust.org/news).

Migraine Trust Research Update

In Migraine News 107 (March 2013) we announced that Dr Anna Andreou had begun a research project funded by The Migraine Trust. Her research is focused on looking at the brain mechanisms that trigger head pain and neurological dysfunctions during migraine attacks. She is also investigating how dysfunction of a brain area called the hypothalamus might be a potential trigger for a migraine attack.

Now that the first year of her three-year project has come to an end, we asked Anna how the research was progressing and what she had discovered so far.

“In an era where no government funding supports any type of headache research, The Migraine Trust fellowship has helped to establish a Headache Research Programme in the UK within one of the world’s leading research institutions.

The research has been very novel and has so far identified the brain areas that become activated at the early stages of an attack, before the actual head pain progresses. The next steps will focus on identifying within these areas the importance different neuronal receptors could potentially have in the initiation and progression of head pain.

Gaining such important information will better assist us in identifying the actual pharmacology involved in the modulation of these brain areas and serve our bigger goal which is the development of ultimate migraine treatments.

Beyond research, through this fellowship The Migraine Trust is aiming further to introduce teaching of Headaches within the Medical School and thus provide fundamental training to undergraduate medical students. This will enable doctors to better understand and treat migraine in the future.”
The European Medicines Agency’s Committee for Medicinal Products for Human Use (CHMP) has conducted a review of the use of methysergide and has made new recommendations following reports of fibrosis seen with methysergide use. Fibrosis is a condition in which fibrous (scar) tissue accumulates in the body’s organs, potentially damaging them.

Wendy Thomas, The Migraine Trust’s Chief Executive, attended meetings with the European Medicines Agency, to put patients views on retaining methysergide for the treatment of intractable migraine and cluster headache.

Methysergide medicines are now only to be used for preventing severe intractable migraines and cluster headaches (a type of severe, recurring headache on one side of the head, usually around the eye) when standard medicines have failed. Methysergide should no longer be used to treat any other health conditions.

Methysergide treatment will only be considered for:
- Prophylactic treatment of severe intractable migraine (with or without aura) in adults, when treatment with standard medicines has failed. Previous treatment must have included treatment with medicines of other classes for at least 4 months at the maximum tolerated dose;
- Prophylactic treatment of episodic and chronic cluster headache in adults when treatment with standard medicines has failed. Previous treatment must have included treatment with medicines of at least 2 classes for a minimum of 2 months.

Methysergide treatment can continue with new restrictions

The Committee noted that there is evidence of the effectiveness of methysergide when used for prevention in those who regularly get migraines and cluster headaches and for whom treatment options are limited.

The Committee noted that there is evidence of the effectiveness of methysergide when used for prevention in those who regularly get migraines and cluster headaches and for whom treatment options are limited.

The prescribing information for physicians and information in the patients’ information leaflet will be updated. The CHMP recommendations will now be forwarded to the European Commission, which will issue a final legally-binding decision.

The identification of a manufacturer for methysergide is being pursued, however, there is no definite information as of yet.

Patients who have any questions should speak to their doctor or pharmacist.

APPG on Primary Headache Disorders Inquiry

In October, the All-Party Parliamentary Group (AAPG) on Primary Headache Disorders launched an inquiry to probe care for sufferers in England. 5.54 million people across England require care for primary headache disorders, which includes migraine, tension-type headache and cluster headache. Current evidence suggests that headache services in the UK are inefficient and inadequate, failing to address the significant burden of primary headache disorders on the NHS and the economy.

The inquiry will investigate the current provision of care for headache patients in England. It will build a body of evidence to examine whether opportunities exist in the new NHS system to improve patient care through the design and commissioning of cost-effective headache services.

The group invited patients, health professionals and service providers to contribute written evidence and two oral evidence sessions were held in parliament in December and January, chaired by Jim Fitzpatrick MP.

A full report with the panel’s recommendations will be published later this year. To find out more about the work of the APPG on Primary Headache Disorders visit www.headacheuk.org.
Government to improve support for school children with health needs

The Government has announced that new legislation will be amended to ensure that children with long-term health conditions, including migraine, receive the support they need while at school.

Following months of campaigning by the Health Conditions in Schools Alliance, of which The Migraine Trust is a member, we are pleased that the Government has announced that all schools, including free schools and academies, will have a legal duty to make appropriate arrangements for supporting pupils with long-term health needs under the Children and Families Act, which will come into place in September 2014. This will be supported by new statutory guidance that will be issued next year.

Under the current system, children with long-term health needs do not always get the additional support in school they need as a result of their condition. While some schools already offer excellent support for children with health conditions, there are many examples where children with migraine and other health conditions experience avoidable ill health and are effectively excluded from fully participating in their education and hindered in meeting their full academic potential.

The Migraine Trust will continue to work closely alongside the other members of the Health Conditions in Schools Alliance to ensure that the Government’s statutory guidance will help schools understand what they need to do and how to do it. This new legal duty is a very positive development for children with migraine and other long term health conditions.

“Schools, including free schools and academies, will have a legal duty to make appropriate arrangements for supporting pupils with long-term health needs.”

Navigating neurology services: helping strategic clinical networks to be a success story

The Neurological Alliance launched a report in September 2013 which sets out their recommended blueprint for the strategic clinical network (SCN) for neurological conditions.

Following the announcement in 2012 that neurology would be included in the first wave of NHS England’s SCNs, The Neurological Alliance, of which The Migraine Trust is a member, has been working with its members, patients, clinicians and those involved in setting up SCNs, to determine what the priorities for the SCN should be.

The Alliance’s report, ‘Navigating neurology services: helping strategic clinical networks to be a success story’, brings together the views of the neurological community on the challenges ahead and what the SCN’s immediate priorities should be. It highlights eight priority areas on which we believe the SCN should be focused on.

In particular, The Neurological Alliance thinks the SCN should:

- Gather data and intelligence on neurological conditions so commissioners can identify the problem areas and understand how they need to tackle them.
- Involve and empower patients and carers in developing helpful tools and resources that can be used by people with neurological conditions and those who care for them.
- Support integration between the different services and organisations with which people with neurological conditions come into contact.

The Neurological Alliance does not underestimate the challenge faced by the SCN in improving neurological services, which have historically lacked the same clinical and political prioritisation that has been given to other condition areas. The Alliance is, however, optimistic about the SCN’s ability to succeed in delivering the type of turnaround programme that is needed for neurological services. To read the full report visit www.migrainetrust.org/news.
Increasing knowledge of the varieties of 5-HT [serotonin] receptor and the development of pharmacological agents that act specifically on certain receptors should give greater insight into the cause of migraine and increase the efficacy of treatment.

A Life Under Damocles Sword
Part 2

Brett Gooden, MD, PhD

So, what have I learned from a life of migraine, medicine and science?

One spring day in 1972, I was working in a laboratory in the beautiful Pocono Mountains of Pennsylvania. The lab was established by Professor Stewart Wolf, protégé of Harold Wolff, about whom I talked in Part 1. As I assiduously jotted down my experimental results in my lab book – no laptops then – Stewart entered the room and glancing at me said in his authoritative air, “Migraineurs make great secretaries.” I was taken aback and held my tongue, but I turned this comment over in my mind as the years went by and eventually came to the conclusion that he was probably right, not because of any genetic tendency, which I felt he had inferred, but because migraineurs never know how much useful time they have before Damocles’ Sword might fall again. Naturally we migraineurs become hyper-efficient in our work, we have learned to cram as much work into our pain-free time as we can.

But what of the mechanism of migraine, its prevention and treatment? Did I learn anything from my life in science and medicine? Yes, I saw great changes in the understanding of migraine and its treatment over half a century. Any scientist worth his salt will tell you that one experiment may count for little on its own. Significant advances in science are made after repeated experimentation by scientists working independently, all coming to the same conclusion. My life is only one experiment but of course it has profound significance for me.

Before I discuss my personal experience with migraine treatment, let us look briefly at the basic mechanism underlying brain function. The brain consists of billions of nerve cells. These cells communicate with each other across small junctions called synapses. Tiny electrical currents move over the surface of nerves, but fascinatingly at the synapse the communication from one nerve cell to the next is achieved not by an electrical current, but by a chemical messenger or chemical transmitter. There are a number of chemical transmitters in the brain. Each nerve uses a specific chemical transmitter.

The transmitter is stored in the endings of nerves (Figure 1 – Schematic of nerve synapse and its function). As a wave of electricity passes over the nerve ending, it causes the release of the transmitter from the nerve ending. The transmitter diffuses across the gap, called the synaptic cleft, between one nerve cell and the next and attaches to specialized structures on the body of the second nerve cell. These structures are called receptors and there are specific receptors for each type of chemical transmitter. Once the transmitter has ‘docked’ on a critical number of receptors, a wave of electrical activity is triggered which is conducted over this second nerve cell. The transmitter is then released from the receptors, diffuses...
across the synaptic cleft in the reverse direction and is absorbed back into the ending of the first nerve cell by a pump located in the wall of the nerve ending.

The nerve transmitter called serotonin plays a vital role in brain function. In 1948 Dr. Maurice Rapport determined the structure of serotonin at Columbia University. Serotonin was known at the time to cause marked constriction of some large arteries. In 1953 serotonin was discovered in the brain of mammals and ten years later it was suggested that it played a role in mental illness. In 1960, it was shown that a slow intravenous infusion of serotonin could relieve a migraine headache. This was a pivotal finding. A year later, Dr. Federigo Sicuteri, about whom I spoke in Part 1, and his colleagues reported an increase in the urine of a breakdown product of serotonin during a migraine headache. These findings suggested that the onset of a migraine might be heralded by a fall in the blood concentration of serotonin and in 1967 the levels of serotonin in the blood were measured between and during attacks (Figure 2 – First experiment to show serotonin level in blood decreases with migraine headache). It was found that the serotonin level fell by an average of 45% during the migraine. Unfortunately the clinical use of serotonin as an antimigraine agent was restricted by its significant side effects.

I had relied on ergotamine to treat my migraine headaches for 40 years. Ergotamine is derived from ergot, a fungus that infects a variety of cultivated grains. It has been used in the treatment of migraine since 1926 and like serotonin is a powerful constrictor of arteries, but it also has a significant stimulating effect on serotonin nerve receptors. So ergotamine is referred to as a serotonin agonist because it mimics the physiological action of serotonin and has the same physiological effect. Professor Harold Wolff believed that ergotamine stopped a migraine because it constricted the cranial arteries including the temporal artery (see Part I). But ergotamine may prevent a migraine not by its arterial constricting effect but by its serotonin agonist effect on serotonin nerve receptors. (Figure 3 – Serotonin nerve synapse at which ergotamine is mimicking serotonin thereby restoring normal nerve transmission). So during a migraine headache being treated with ergotamine, the ergotamine presumably attaches to the serotonin nerve receptors and mimics the effect of serotonin thereby compensating for the lack of serotonin at the receptors. In this way, the ergotamine restores normal nerve transmission at the serotonin nerve synapse.

In Part 1, I described how the medication called escitalopram had released me from profound depression and a lifetime of migraine headaches. Why was this so? Escitalopram is believed to compensate for the low serotonin level at the synapses of the depressed brain, not by acting as an agonist like ergotamine, but by blocking the serotonin uptake pump (Figure 4 – Escitalopram blocks serotonin uptake pump allowing serotonin to accumulate in synaptic cleft and hence on receptors). These anti-depressants are therefore called serotonin re-uptake inhibitors, a term which is sometimes abbreviated to SRI. So although there is a much reduced amount of serotonin at the serotonin receptors initially, if the re-uptake pump is blocked, the serotonin increases in the synaptic cleft and hence also on the receptors. The nerve transmission at these synapses is restored and the depression lifts.

And why did the escitalopram release me from my migraine headaches when no other preventative medication had done so? Just like my depression, I believe that my migraine headaches were due to a low level of serotonin. As I reduced the ergotamine, the escitalopram prevented the onset of a migraine, not by the agonist effect of ergotamine, but by the process of blocking serotonin re-uptake at the nerve endings (Figure 4). In this way, naturally released serotonin accumulated in the synaptic clefts and then the receptors and the migraine was prevented. Preliminary research using escitalopram as a preventive agent in migraine showed significant improvement in migraine frequency, duration and intensity. A larger clinical study may
throw more light on its potential in the prophylactic treatment of migraine.

I have already mentioned in Part 1 some simple experiments which I performed on myself during migraine headaches. One of these entailed face immersion with breath-holding. Why did this simulated dive attenuate the migraine? One theory of migraine is called the trigeminovascular theory. The trigeminal nerve is one of the so-called cranial nerves. It supplies feeling to the face and forehead and activates the muscles of chewing. The trigeminal nerve passes into the brain stem of the central nervous system. The brain stem is located between the base of the brain and the spinal cord (Figure 5 – Brain stem nervous structures controlling heart rate, blood vessels and breathing). Here the trigeminal sensory nerves form synapses with secondary sensory nerves that connect to the brain. These trigeminal nerve synapses cluster to form a structure called the trigeminal nerve centre or nucleus. The trigeminovascular theory claims that this nerve centre becomes inappropriately active and sends nerve signals to the cerebral arteries. Here chemicals are released in the region of these arteries which produce local inflammation and pain.

In the brain stem are also located the centres for controlling breathing, heart rate and blood vessels. My colleagues and I had shown that when one performs face immersion, sensory nerves in the skin of the face around the nose, eyes, forehead and scalp are stimulated (Note: these latter three sites are all areas in which migraineurs frequently experience their headache) and send signals via the trigeminal nerve to the brain stem activating all these other centres including the blood vessel constricting centre (Figure 6 – Schematic of the mechanism of the diving response). We know that during a migraine there is an increase in brain stem nervous activity which it has been suggested may affect our perception of pain in some way. So both the diving response and a migraine headache involve the brain stem centres. Could the diving response have interfered with the suggested dysfunction in pain perception? Further research in this area might be useful.

The other experiment I performed was to breathe pure oxygen for a few minutes. This procedure also attenuated my migraine. Why? Changes in the blood concentration of oxygen are detected by sensors in the circulation which send this information to the breathing control centres in the brain stem. Perhaps this input to the brain stem can also suppress the perception of the pain of migraine. Further food for thought. Although I did not know it at the time, oxygen therapy for migraine was first reported in 1939. Recently there has been a flurry of interest in this area again. Migraine profoundly affected my life. It confirmed for me in a dramatic way how central the role of brain chemistry is in making us the people that we are and how abnormal functioning of these processes can fundamentally affect our lives. Each migraineur has his or her own personal story to tell. What may help one, may not help another.

In summary, then, it seems likely that migraine is a genetic disorder of serotonin nerve transmission. This basic defect leads to the episodic dysfunction (abnormal function) in the brain stem nerve centres controlling pain perception in the distribution of the trigeminal nerve (trigeminal nerve centre), constriction followed by dilatation of arteries (vasomotor centre) and nausea and vomiting (vomiting centre) – the classical cascade of clinical events that occur during a migraine headache.

We are now much better equipped from a technological standpoint to understand the mechanism of migraine and this in-depth knowledge will undoubtedly lead to more effective preventative and acute treatments. We should all thank The Migraine Trust for the wonderful support that it gives not only to migraineurs, doctors and nurses but also to the scientists who are striving to make it possible for migraineurs to live more pain free and fulfilling lives.
References


Figures

Figure 1. The junction or synapse between two adjacent nerve cells at which the chemical transmitter, in this case serotonin, provides the means by which a nerve signal is transmitted from the cell on the left to the one on the right (© Gooden, 2012)

Figure 2. The first experiment to show that serotonin level in the blood decreases in association with a migraine (HA = headache; serotonin concentration in micrograms per 109 platelets. Modified from Anthony, Hinterberger and Lance, 1967)

Figure 3. The serotonin-nerve synapse at which ergotamine is mimicking serotonin thereby compensating for the presumed deficiency of serotonin at the receptors and so restoring normal nerve transmission (© Gooden, 2012)

Figure 4. Escitalopram blocks the serotonin uptake pump and so allows the serotonin to accumulate in the synaptic cleft and hence on the receptors, thereby improving the function of the synapse (© Gooden, 2012)

Figure 5. Brain stem nervous centres controlling heart rate, blood vessels and breathing. The brain stem is a vital component of the central nervous system which lies between the base of the brain and the spinal cord. Notice the close proximity of the trigeminal nerve centre which appears to play a central role in the diving response and likely the cascade of symptoms and signs of a migraine headache (© Gooden, 1970)

Figure 6. Mechanism of the human diving response (Modified from Gooden, 1994, see Part 1)
Does Migraine Damage the Brain?

At the start of Migraine Awareness Week in 2013, stories appeared in the media that raised questions about whether migraine can cause harmful changes in the brain (‘Migraines can cause permanent brain damage’, Telegraph, 29th August 2013; ‘Migraines can cause permanent brain damage, study finds’, MailOnline, 28th August 2013). Unsurprisingly, enquiries were received at The Migraine Trust and we asked our medical Trustees for some help in interpreting the research.

Migraine research sometimes includes the use of imaging technology, or scans, to examine the brain structure and compare the brain of migraine sufferers with those who are not sufferers. Therefore, trying to understand whether there are differences in the structure of the migraine brain might help in developing new and more effective treatments for migraine.

In a paper by Dr A Bashir and others, the authors reviewed 19 earlier studies, 13 of which were studies of people who attended migraine clinics. Compared with non-migraineurs, those with migraine with aura (but not those with migraine without aura) had a small but statistically significant increased appearance of white-matter abnormalities. Infarct-like lesions were statistically more common in people with migraine with aura than in those who had migraine without aura. However, reassuringly, these were no more common in either group of migraineurs than in the people without migraine. The research shows that people who have migraine without aura are not at any important risk for either white-matter abnormalities or infarct-like lesions compared to people without migraine. In addition, there are no cognitive (thinking) problems caused by migraine or by having an MRI scan similar to those in the studies. The research shows that people who have migraine without aura are not at any important risk for either white-matter abnormalities or infarct-like lesions compared to people without migraine.

Professor Peter Goadsby, Director of the NIHR-Wellcome Trust Clinical Research Facility at King’s College Hospital, London, and Trustee of The Migraine Trust, believes that resolving these types of questions is hugely important and will require a well-funded, large-scale, population-based imaging study. ‘To understand what happens with time to the human brain in health and disease would be a wonderful legacy for the next generation’ he said.

References:
Transcranial Magnetic Stimulation (TMS) for Migraine

Neurostimulation devices have been of increasing interest for the treatment of primary headaches in recent years. New minimally invasive and non-invasive devices are being tested for migraine and other primary headaches. Results from initial experiences and clinical trials were presented at the European Headache and Migraine Trust International Congress (EHMTIC) in 2012.

The Migraine Trust is pleased that, in January 2014, the National Institute for Health and Care Excellence (NICE) published guidance supporting the use of a new handheld transcranial magnetic stimulation (TMS) device for the treatment of migraine.

There are two non-invasive stimulation techniques being actively developed in the UK: TMS and vagal nerve stimulation (VNS). At present TMS has a better evidence base although pilot studies of VNS may show it to be useful in the treatment of cluster headache, one of the most painful of all headache disorders.

The only currently available TMS device in the UK is the Spring Total Migraine System produced by eNeura. The device is held to the back of the head and when the buttons are pressed, the device delivers a single pulse magnetic field that passes through the skull to the cells on the surface of the brain. The device delivers either single (sTMS) or repeated (rTMS) magnetic pulses. The frequency, intensity, duration and interval times of pulses can be varied. The device automatically records treatments in an integrated headache diary, which can be used to identify headache patterns and trigger factors. It is possible to continue to use regular migraine medications in addition to using the device. In the original trials, 39% of users were rendered pain-free within two hours. These trials only included people with migraine with aura, however, recent studies have suggested that TMS works equally well for people with migraine without aura. The studies so far showed that there were no serious risks associated with having the procedure; however, further research is needed.

TMS may provide a new treatment option for those migraine sufferers for whom currently available acute medication is ineffective, unsuitable (in pregnancy, for example) or contraindicated.

The Spring TMS device is currently available only on the recommendation of doctors specialising in headaches. A specialist headache clinic should decide which patients should be offered this procedure and it should only be used under the direction of doctors specialising in managing headaches. The procedure is not intended to cure migraine and reduction in migraine symptoms may be moderate.

NICE said that more research on magnetic stimulation of the brain for treating and preventing migraine is needed.

For further information visit www.migrainetrust.org/news or telephone The Migraine Trust: 020 7731 6975.

A Cross-Channel Challenge

The autumn of 2013 saw Migraine Trust supporter Katie take on not one, but two challenges! First she ran La Grande Classique, a 16KM course from the foot of the Eiffel Tower to the Palais Versailles. Then, if that wasn’t enough, she also took part in the Great South Run in October. Katie raised over £150 for The Migraine Trust – merci beaucoup, Katie!

Remember a Charity Week 2013

In September 2013, Fundraising and Events Officer Holly Lyons met veteran journalist and newsreader, Angela Rippon, to raise awareness of the importance of gift in wills to UK charities, including The Migraine Trust.

“I’ve supported a number of charities during my lifetime, and it’s something I want to continue to do as part of my legacy. Around 40,000 people will make or amend a Will this week alone, raising £40 million for good causes,” explains Angela. “If just 6% more people included a gift to charity in their Will, we could raise an additional £40m this week, providing essential funding to help charities to continue their good work.”

You can find out more about leaving a gift in your Will by visiting www.migrainetrust.org/remember-us-in-your-will.

Run to the Beat

In September 2013, The Migraine Trust’s first Run to the Beat team descended on Greenwich Park. It was a fantastic day with stages at several points around the half marathon course playing music to motivate our runners and, as a reward, special guest Jessie J played live at the end of the race to help the 19,000 runners celebrate their achievement. Congratulations to Team Migraine – James, Rosie and Louise – who together raised an amazing £1,181.

Great North Run

In September, Terry took part in the Great North Run to support his wife Sarah, who suffers from migraine. Terry said, “After being at last referred to a headache clinic [Sarah] has been diagnosed with Chronic Migraine. They told us about a small charitable organisation called The Migraine Trust. What wonderful people, supportive, giving good advice, and reassurance. But best of all THEY LISTEN. I think they do a wonderful job.”

Thanks to Terry running the UK’s largest televised half marathon in his Migraine Trust running vest we hope a few more people will know about us. As well as helping us to raise awareness, Terry also raised a fantastic £383!
London Marathon

On April 13th our London Marathon team will take to the streets of the capital to raise funds and awareness for The Migraine Trust. Our 7-strong team have all pledged to raise £1,500 each, giving our team a target of £10,500. You can find out more about our team and sponsor them by visiting www.migrainetrust.org/events and selecting the London Marathon. If you would like to apply for a guaranteed Migraine Trust place in the 2015 London Marathon, please email fundraising@migrainetrust.org to find out more.

Yorkshire Marathon

In October, Sue took part in the Yorkshire Plusnet Marathon to raise money for migraine to support her partner, David, who suffers from hemiplegic migraine. Sue said, “I am running for The Migraine Trust as my partner, David, has been suffering badly with something called ‘hemiplegic migraine’ for the last 4 years. It’s pretty horrible when he has an attack because it comes on so quickly and resembles a stroke. All forms of migraine are debilitating and this type particularly so and there isn’t much known about it.”

Sue ran the marathon in just over four hours and raised an amazing £1,417.74. Everyone here at The Migraine Trust would like to say a big thank you to Sue for all her hard work!

British 10K 2014

Once again we are looking for a team of enthusiastic volunteers to take part in the British 10K in London this July. The British 10K is the UK’s most prestigious and sought-after 10km road race which is staged on the world’s greatest route through the heart of central London. 25,000 runners fill the streets of the nation’s capital and get the unique chance to run past many of the country’s greatest landmarks including Big Ben, the London Eye, St Paul’s Cathedral, Trafalgar Square and Westminster Abbey. Last year, our 6-strong 10K team raised £1,200 for The Migraine Trust; can you join our team and help us to beat it in 2014?

Request an application form by emailing fundraising@migrainetrust.org or calling 020 7631 6976.

Cardiff Half Marathon

In October, Steve joined around 18,000 people at the start line of the Cardiff Half Marathon. Steve completed the half marathon in an amazing time of 2 hours, 10 minutes and raised an even more amazing £267.50 for The Migraine Trust. Well done, Steve!

 Movember for Migraine

Men growing moustaches in November is usually associated with male cancers, but in November 2013, Michael chose to be a little different and grew a moustache to raise money for The Migraine Trust. Through the simple act of having a moustache for a month Michael raised a fan-‘tache’-stic £391 for The Migraine Trust. Great work Michael!

Daisy’s NaNoWriMo Challenge

Proving that you don’t have to be the athletic type to fundraise for The Migraine Trust, Daisy chose to take part in the NaNoWriMo Challenge to write a 50,000 word novel in one month. To use the challenge to raise awareness of migraine, Daisy made the central character in the novel a super hero, who suffers from migraine. Daisy completed the challenge and you can read her novel in full by visiting http://www.amateur-writing.com/stories/#4343, and raised a fantastic total of £306.25 – thank you Daisy!
I have menstrual migraine but my GP won’t send me for a hysterectomy. **Why not?**

In order to answer this question, I think it’s important to understand the female reproductive organs, i.e. the uterus (womb) and the two ovaries each side of the uterus. The ovaries contain the eggs and also produce the sex hormones oestrogen and progesterone. At the beginning of each menstrual cycle, some of the eggs will start to mature under the influence of hormones produced by the ovaries. In the middle of the cycle, one egg (sometimes more) will ovulate. If the egg is not fertilised it will get absorbed by the body but more importantly the level of hormones fall. This fall of hormones triggers the lining of the womb to break down and be shed through the vagina – called menstruation.

It is this withdrawal of hormones that acts as a trigger in women with menstrual migraine or menstrual-related migraine. So, if someone is considering a hysterectomy to treat menstrual migraine, it would not help as the ovaries would need to be removed.

There are a few diagnoses where for a small minority of women, surgical removal of the ovaries is the only measure that will allow them to continue a normal life. It is a very controversial treatment and is therefore very rare.

The first options are non-surgical ways of putting the ovaries out of action. Once the ovaries are out of action (in whatever way) the woman must take hormone replacement therapy until the average age of menopause (age 55) to prevent the long term consequences of oestrogen deficiency (e.g. risk of osteoporosis).

One way to suppress the hormonal cycle is to use different forms of hormonal contraception. The combined contraceptive pill, one progestogen-only pill, the progestogen-only injection and implant will work by stopping ovulation.

I was considering using the Mirena coil for contraception. I’ve read on internet forums that this makes many women’s migraine worse. **Is this true?**

The Mirena IUS’s contraceptive effect is mainly to stop implantation and reduction in sperm penetration through changes of cervical mucus. The majority of women using this (>75%) will continue to ovulate. The women who do experience an improvement of their migraines with an IUS might do so because the IUS stopped ovulation.
March
10-16 – Brain Awareness Week
A global campaign to increase public awareness of the progress and benefits of brain research. Visit www.dana.org/BAW to find out more.

29 – Managing Your Migraine: YORK
Come along to meet local migraine experts, staff from The Migraine Trust and learn more about migraine, its management and migraine in employment.

April
13 – Virgin Money London Marathon
Sponsor one of our marathon runners at www.justgiving.com/migrainetrust.

May
24 – Managing Your Migraine: BELFAST
We will be travelling across the Irish Sea to hold an information day for people living with migraine in association with British Association for the Study of Headache. The event includes presentations by migraine experts with the chance to ask your questions.

June
21 – Managing Your Migraine: KEELE/STOKE-ON-TRENT
Come along to meet local migraine experts, staff from The Migraine Trust and learn more about migraine and its management.

July
13 – British 10K 2014
Put on your running shoes and join our 10K team to raise money for migraine and awareness of this debilitating condition. Contact The Migraine Trust to apply for a place today.

For more information about any of our events please visit www.migrainetrust.org/events, email events@migrainetrust.org or call 020 7631 6976.

Everything we do for migraine sufferers across the UK is funded by voluntary donations. Please, give what you can today and help us to continue our vital work.

£32.60, which will pay for two hours’ information support, making sure we can answer the telephone helpline when it rings.

£20, which would cover the costs of two information packs sent to migraine sufferers who have contacted us for the first time.

£285, which would pay for a full day of dedicated migraine research – bringing us one day closer to better treatments and ultimately a cure.

My own preferred gift amount of: £___________

I enclose a cheque payable to The Migraine Trust OR Please debit my credit/debit card

Card type: 

Card holder’s name: 

Card number: ___________ ___________ ___________ ___________

Valid from: ______ / ______ Expiry date: ______ / ______ 3 digit security number: ___________

Issue number (Maestro only): 

Signature(s): Date: 

Your details:
Title: 

First Name: 

Surname: 

Address: 

Postcode: 

Telephone: Email: 

Please use the freepost envelope provided or return to FREEPOST RSRB-ZYSK-GGCC

The Migraine Trust, 52-53 Russell Square, London WC1B 4HP

Thank you
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 factsheets and packs. You can also subscribe to The Migraine Trust’s e-bulletin. The Migraine Trust is a registered charity funded entirely by voluntary donations from individuals, charitable trusts and corporate sponsors. 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.

Find us on Facebook, Twitter and Justgiving.com

Telephone: 020 7631 6970
Fax: 020 7436 2886
Email: info@migrainetrust.org

Website: www.migrainetrust.org

The Migraine Trust, 52-53 Russell Square, London, WC1B 4HP

A company limited by guarantee incorporated in England no.3996448

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