Dr Zouhair Laaouina

Introduction

As part of the IHS Visiting Professor programme, Dr Françoise Radat from the Centre Douleur Chronique, Chu Pellegrin, Bordeaux, France, visited the Annual Meeting of the Neurological Society of Morocco. The meeting was a great success, with approximately 60 neurologists from all over Morocco in attendance, all of whom enjoyed the session.

The president of the Neurological society, Dr Elalaoui, welcomed Dr Radat and thanked IHS for sponsoring this headache session. Dr Laaouina then informed the audience that this headache session is part of the new headache programmewhich IHS has introduced in 2012 in countries which do not have headache centres and whose physicians are unable to attend International congresses in headache. He told them that Morocco is one of the first to benefit from this initiative.

Dr Radat and Dr Saadia Aidi then presented excellent speeches. Dr Radat presented her 30-minute speech about psychiatric comorbidity in migraine. Dr Aidi followed this by talking for 30 minutes about tension-type headache. Following the presentations, Dr Radat spent a few minutes talking about overuse of headache medication, and this was followed by a very interactive panel discussion about the three subjects presented. Indeed, the delegates were so inspired to ask questions that in the end it was difficult to close the session.

Psychiatric comorbidity in migraine
Dr Françoise Radat

Dr Radat began by defining comorbidity as the appearance of a second complaint during the evolution of the disease. The most common comorbidities associated with migraine are mood disorder and anxiety disorder.

Anxiety disorders are more much common in migraine sufferers than non-migraine sufferers:
- general anxiety 5-times more common
- panic disorder 3–5-times more common
- phobia disorder 2-times more common.

Migraine sufferers also have 2–4-times greater risk of depression than non-migraine sufferers, and 20–30% of all patients with depression have migraine. In some headache centres, almost half of patients who visit are depressed, and there is a recognised association between anxiety, depression and migraine.

Migraine sufferers often do not realise they are depressed. The symptoms they describe as migraine symptoms are actually often symptoms of depression (e.g. they cannot face life because of their migraines, people cannot count on them, nobody understands them, they feel there is no solution, they have no hope that the pain will ever be relieved). Therefore, clinicians need to search closely for symptoms of depression when interviewing migraine sufferers.

In 1991 Breslau et al. found that suicide is more frequent in migraine sufferers than non-migraine sufferers (Psychiatry Res 1991;37:11–23). This finding was confirmed in a recent study by the same author (Headache 2012;52:723-731). This is the case even when there is no depression associated with the migraine.
When treating both migraine and depression we should treat the depression using selective serotonin reuptake inhibitors and keep tricyclic drugs for the migraine at a low dose (12–50 mg).

In a French cross-sectional study called Grim 3, it was found that when the comorbidities of both depression and anxiety are present in migraine sufferers, the impact is high (MIDAS) and quality of life (SF12) is low. The authors also noticed negative coping behaviours in these patients such as avoidance behaviour and exaggeration of their situation, and these negative behaviours can also lead to abuse of medication. They found that the comorbidities of depression and anxiety were 2-times more frequent in patients with chronic migraine than those with episodic migraine, and that when comorbidities exist, patients are less satisfied with acute treatment for their migraine attacks (Cephalalgia 2009;29:338–350).

Divalproate can be used in migraine associated with mood disorder, and Dr Radat also suggested relaxation therapy for migraine sufferers who also experience anxiety.

**Tension-type headache**

**Dr Saadia Aidi**

In her introduction, Dr Aidi noted that tension-type headache (TTH) is the most common form of headache, with episodic form being the most frequent. She defined tension-type headache as classified in the International Classification of Headache Disorders (ICHD-II).

- The 1-year prevalence in the general population is estimated to be 30–80%
- The average age of onset is between 25 and 30 years
- Prognosis for episodic TTH
  - 75% continue to have attacks
  - 25% develop chronic TTH
- Prognosis for chronic TTH
  - 31% continue to have attacks
  - 21% develop overuse of medication
  - 48% return to episodic form with or without prophylactic treatment
- TTH has greater impact on work than migraine, with absenteeism of 820 days per year per 1000 employees versus 270 days per year for migraine.

Dr Aidi cited some differential diagnoses like migraine, chronic migraine, headache attributed to medication overuse and chronic daily headache, and emphasised the importance of searching for abuse of medication as a possible cause of headache.

The most common headache associated with TTH is migraine. In her description of the pathophysiology of TTH, she described two mechanisms:

- Peripheral mechanism: muscle contraction
- Central mechanism: sensitisation of neurons in the upper cervical spine.

She noted the implication of some other factors, such as psychological factors.

The main treatment for acute attacks is NSAIDs. Prophylactic treatment is indicated in frequent episodic TTH and in chronic TTH, and can be pharmacological or non-pharmacological. Tricyclic drugs such as amitriptyline are important in prophylactic treatment, and botulinum toxin can be used as prophylactic treatment in chronic TTH. Non-pharmacological treatment such as relaxation, biofeedback, stress management, acupuncture can also be utilised.
Dr Laouina, Dr Aida and Dr Radat

The audience

Dr Elalaoui (Neurologist and the President of the Moroccan Neurological Society), Dr Radat and Dr Laouina