

# Letter to the Editor

Dear Dr. Gorman:

June 18, 2003

I read with interest your article in the June 2003 *CNS Spectrums* (Volume 8, Number 6) which dealt to a large degree with, as your editorial was titled, "Migraine and Its Connections in Neurology and Psychiatry."

In your editorial you stated, "Treatment relies on palliative measures, including a variety of analgesics, some of them have abuse potential..." You go on to list as migraine-treating medications "ergotamine,  $\beta$ -blockers, anticonvulsants, and serotonin-enhancing drugs." You also said "antidepressants generally are not effective in treating migraine headache..."

I would like to deal with each of these statements. First of all, over the last 10 years there has been a fundamental revolution in the abortive treatment of migraines and, as you know, there are now seven "triptans" available, the first of which is sumatriptan, which remains in many respects the "gold standard." Triptans have a high frequency of success in aborting migraines and many of them have a very low frequency of migraine recurrence. They are really excellent drugs and they have created a virtual revolution in the treatment of migraines.

You also state that many medications used in the treatment of migraine "have abuse potential." This is certainly true since, unfortunately, many physicians (who should know better) have continued to use mixed narcotic analgesics, many of which create dependency but, almost equally important, cause a condition called "analgesic rebound." Migraineurs who use these drugs with more than a minimal frequency, develop chronic daily headaches of a migrainous quality which are very refractory to treatment and often render the triptan less effective.

You also state that "ergotamine" can be used. Caution is warranted when patients receiving triptans consider using an ergot-type preparation since both drugs vasoconstrict and, in fact, when a person is successfully being treated with triptans, they will not need ergotamine, generally.

You state that, "antidepressants generally are not effective in treating migraine headache." Tricyclic antidepressants are, indeed, first-line prophylactic agents in the treatment of migraine. Most prominent are amitriptyline and nortriptyline. Unfortunately, many have undesirable side effects and so, to a large degree, selective  $\beta$ -blockers

and newer antiepileptic drugs used in the treatment of partial complex seizures are beginning to replace tricyclics.

You mention topiramate. It is certainly a useful drug in migraine prophylaxis and is probably currently being reported as having a higher overall response rate than you mention (35.3%). Other antiepileptic drugs are also increasingly used.

The June 2003 issue of *CNS Spectrums* was particularly interesting as it relates to the comorbidity of migraine. I am board certified in psychiatry, Board eligible in neurology, and I specialize almost exclusively in the treatment of migraine. I have a particular interest in these comorbidities and I am in the process of delivering a series of lectures to psychiatrists, in the Rocky Mountains region. This is somewhat of a "pilot program" to encourage psychiatrists to treat migraine. Of course, many prominent mood disorders are comorbid with migraine. There is considerable accumulating evidence that successful treatment of migraine lowers the overall disability from psychiatric disorders.

Psychiatrists are astonishingly underrepresented among those medical specialists who treat migraine. This is difficult for me to understand, considering the fact that neurologists, who virtually claim the field, generally have less knowledge of brain biochemistry than psychiatrists, particularly relating to serotonergic and dopaminergic mechanisms.

Yours very truly,  
Arthur C. Roberts, MD

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*Dr. Roberts is in private practice dealing almost exclusively with headaches, neck disorders, and head injury in Colorado Springs, Colorado. He is a consultant to AstraZeneca, GlaxoSmithKline, and UCB Pharma.*

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Dear Dr. Roberts:

*We are grateful for your important comments about our issue on migraine headaches. We invite our readers to similarly correct our errors and acknowledge when we are right.*

Sincerely,  
Jack M. Gorman, MD  
Editor, *CNS Spectrums*



***Depression has long been defined by emotional symptoms such as crying, loss of interest, worrying, and nervousness. But at Lilly, we're exploring the role not only of emotional symptoms but also of physical symptoms in depression, such as vague aches and pains.***

***Depression is both emotional and physical***

Depression has long been recognized as hurting your patients emotionally with symptoms such as loss of interest, crying, worrying, and nervousness. However, your depressed patients often suffer with physical symptoms that can hurt them just as deeply. Although fatigue, as well as changes in sleep and appetite have been commonly recognized as the more traditional physical symptoms of depression, other physical symptoms of depression do exist. Symptoms that are much more painful in nature.

***Patients may suffer the more painful physical symptoms in silence, unaware of their connection to depression***

Many patients who present in your office are likely to complain of only the emotional symptoms of depression. Yet, further questioning may reveal some of the more painful physical symptoms of depression including vague aches and pains in varying degrees of severity, such as vague back pain and shoulder

**We're not reinventing it.**

**We're just taking a closer look.**

and neck pain. Not only may these somatic symptoms be difficult for your patients to describe, they can make the assessment and prognosis of depression challenging.<sup>1,2</sup>

***19 million adults in the United States still suffer from a depressive disorder***<sup>3</sup>

The distressing fact remains, of all the patients treated for depression, approximately only 30% achieve remission of their depression.<sup>4</sup> Three fourths of patients with residual depressive symptoms relapse.<sup>5</sup> And of these patients with residual symptoms, more than 90% had mild-to-moderate general somatic symptoms.<sup>6</sup>

***Imbalances of serotonin (5-HT) and norepinephrine (NE) may contribute to both the emotional and physical symptoms of depression***<sup>6</sup>

Research suggests that both serotonin and norepinephrine play key roles in regulating not only the emotional symptoms of depression but also the physical symptoms of depression. Both 5-HT and NE ascend from the brain stem into the brain where they

mediate the emotional and vegetative symptoms of depression. The two neurotransmitters also descend from the brain stem, down the spinal cord where they regulate somatic sensory perception. Depression may cause dysfunction in both the ascending and descending pathways of 5-HT and NE, which may explain the presence of both emotional and painful physical symptoms.

***Depression hurts both emotionally and physically***

Researchers at Lilly are currently investigating the effect of both 5-HT and NE in depression. For more information, visit [www.DepressionAdvances.com](http://www.DepressionAdvances.com).

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