

A case report on the Impact of Migraine

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Abstract:

Introduction: Migraine headaches are one of the most frequent and debilitate nonfatal diseases known to mankind. Misdiagnosis is common, which can lead to under treatment. Patients frequently self-diagnose and treat themselves, leading in ineffective treatment. As a result, patients may take higher doses in an attempt to get relief from ineffective treatments. It's possible that you'll rebound. A patient's condition and quality of life can significantly improve with proper treatment Patient education is critical in assisting patients in identifying appropriate self-care methods, such as identifying triggering situations and dealing with the chronic nature of their condition. This case study depicts a patient who developed migraines as a result of a neck injury. Ergotamine and caffeine (Cafe got) suppositories were administered as his headaches grew increasingly frequent. He was suffering from everyday headaches and taking ergotamine and caffeine suppositories on a daily basis when he appeared. He was often visiting the emergency room (ED) due to severe headaches. His trigger was identified as cervical spasm, and the ergotamine and caffeine suppositories were stopped. His severe headaches subsided after three the rebound has come to an end. **Main symptoms and/or important clinical findings** :28-year-old male was admitted in A. V. B. R. H. On dated 20-6-21 with chief complaint of fever, headache, chills, myalgias and arthralgias and after physical examination and investigation doctor diagnosed a case of migraine. **The main diagnoses, therapeutic interventions, and outcomes:** After physical examination and investigation doctor diagnosed a case migraine. Tab. Paracetamol 500 mg (BD), Inj. ceftriaxone 1gm IV (BD), Inj. Pantoprazole 40 Mg iv (OD), Inj. Ondansetron 4MG IV (TDS) for 7 days given and calcium and multivitamin supplementary was given for 7 days to enhance immune function. he was took all treatment and outcome was good. Her sign and symptoms was reduced . **Conclusion:** he was response to all medication as well as doctor treatment and her recovery was good.

Keywords: Migraine Disorders, Nausea, Hemiplegic, Familial, Classic Migraine, Cervical Migraine.

Introduction:

Migraine is one of the most frequent and misunderstood illnesses seen in general medicine. Migraine takes a toll on migraineurs and their families on a personal, psychological, social, and financial level. Recent improvements in pathogenesis and acute therapy have the potential to significantly lessen the severity of migraine. Migraine is a debilitating headache that needs long-term therapy. Migraine management using yoga therapy and naturopathy would save money on medications while also improving one's health. Yoga has been demonstrated to enhance condition of life, lessen headache episodes, and reduce medication use. The aim of this case study was to analysis the advantage of Yoga and naturopathy as an adjuvant therapy in migraine patients by looking at clinical outcomes and autonomic function testing.¹

Migraine is a usual clinical condition characterized by irregular bouts of severe headaches, as well as Nausea, hypersensitive, sound, or head movement are some of the symptoms that can occur. Although headache is commonly assumed to be a migraine, it has been clear in recent years that many people with migraine manifestation do not have as a major manifestation, severe headaches. As a primary symptom, these people may experience vertigo, ear discomfort, ear or head fullness, "sinus" pressure, or even fluctuating hearing loss are all symptoms of a sinus infection. Fortunately, therapy regimens that have been proven to be helpful in the therapy of "classic" sinus headache are also beneficial in the treatment of these "atypical" migraine symptoms. Symptoms: Migraines can advance through four stages: prodrome, aura, attack, and post-drome. They commonly begin in infancy, adolescence, or early adulthood. Not everyone who suffers from migraines progresses through all of the stages. Sinus headache is a prevalent clinical condition that is distinguishes by headaches. Headaches with concomitant manifestation such as nausea, sensitivity to light, sound, or head movement occurs on a regular basis. Although migraine is commonly assumed to be a headache problem, it has been clear in recent years that many people with migraine symptoms do not have severe headaches as a primary symptom. These individuals may have vertigo, ear pain, ear or head fullness, "sinus" pressure, or even fluctuating hearing loss as a predominant symptom. Fortunately, therapy regimens that have been proven to be helpful in the treatment of "classic" migraine headaches are also beneficial in the treatment of these "atypical" migraine symptoms. Symptoms: Migraines can advance through four stages: prodrome, aura, attack, and post-drome. They commonly begin in infancy, adolescence, or early adulthood. Not everyone who suffers from migraines progresses through all of the stages. Migraine is a persistent headache disorder marked by episodic attacks of severe pain. These individuals may have vertigo, ear pain, ear or head fullness, "sinus" pressure, or even fluctuating hearing loss as a predominant symptom. Fortunately, therapy regimens that have been proven to be helpful in the treatment of "classic" migraine headaches are also beneficial in the treatment of these "atypical" migraine symptoms. Symptoms: Migraines can advance through four stages: prodrome, aura, attack, and post-drome. They commonly begin in infancy, adolescence, or early adulthood. Not everyone who suffers from migraines progresses through all of the stages. cephalalgia is a persistent headache condition characterized by sporadic attacks of extreme pain, nausea, light and sound sensitivity, and other symptoms of vomiting are common symptoms of these attacks. Around 18 percent of women and 6% of men in the United States suffer from at least one migraine headache every year.²

At the age of 41, our outpatient section was the patient's initial stop. Headaches that come and go have been recorded from the age of eight, with frequency and intensity gradually worsening in recent years. Pain that pulsates unilaterally and is moderate to severe in intensity, focused in the orbital area with front-temporal irradiation, characterized the episodes, nausea without vomiting, and lasted up to 72 hours, and were commonly provoked by psychological stress and physical exertion. There was no aura or trigeminal-autonomic symptoms mentioned by the patient. There was no history of migraines, and the medical history was ordinary. Monthly migraine days (MMD) were reported at 20, and monthly acute migraine-specific medication days (MSMD) were reported at 15. For persistent migraine and medication-overuse headache, the patient met the ICHD-3 criteria. Because of the rising usage of symptomatic medicines, the patient was admitted to the hospital for a week in 2019 to undergo detoxification, but the frequent of misery in the head remained high (MMD 16). Previous preventative medicines (Topamax, beta-blocking agent, metoprolol, tricyclic antidepressant, and olanzapine) were shown to be ineffective, thus in September 2020, adenoimab, an anti-CGRP receptor monoclonal antibody, was provided at a monthly dose of 70 mg. At the outset of the study, the 69 and 67 on the Migraine Disability Assessment Test (MIDAS) and Headache Impact Test (HIT6), respectively. The patient reported a considerable decrease in the frequent and the severity of migraine episodes over the next two months, with only 5 migraine days in the second month and a substantial decrease in the need of intense anti-migraine medication.³

Patient specific information: 28-year-old male was admitted in A. V. B. R. H. On dated 20-6-21 with chief complaint of fever, headache, chills, myalgias and arthralgias and a case of migraine was detected after a physical examination and inquiry by the doctor. A case of migraine was diagnosed after a physical examination and investigation by the doctor.

Primary concerns and symptoms of the patient: Chief complaint of fever, headache, chills, myalgias and arthralgias. These were the primary symptoms which were observed at the time of admission.

Medical, family, and psycho-social history: Present case had history of any medical history of migraine. He belonged to nuclear family and there are four members in his family. All family members are healthy except the patient. Patient looks fatigued, depressed. She had maintained good relationship with doctors and nurses as well as other patients also.

Relevant past intervention with outcomes: No any history of migraine. He was not hospitalized. **Clinical findings:** The patient was conscious and well oriented to date, time and place. Her body built was moderate and she had maintained good personal hygiene. Weight is 58 kg. Her vital parameters are normal. His growth and developments were normal.

Diagnostic assessment: On the basis of patient history, physical examination, abdominal palpation and In ct scan moderate headache was observed, magnetic resonance imaging of brain It may also be useful in determining cause of migraine. Blood investigations were also done. Blood Investigation: WBC :- < 5000 cells/mm³. RBC: - 20,000-40,000 (cells/mcL), IgM and IgG test: - Positive, Platelet count: - 12,000 cells/mm³ and hemoglobin was less 10gm% and other investigations were also done. In urine examination was done.

Diagnostic assessment:

Diagnostic challenging: No any challenging during diagnostic evaluation.

Diagnosis: After physical examination and investigation doctor diagnose a case of migraine.

Prognosis: Was good.

Therapeutic intervention:

Medical management was provided to the patient. Tab. Paracetamol 500 mg (BD), Inj. cefotaxime 1gm IV (BD), Inj. Pantoprazole 40 Mg iv (OD), Inj. Ondansetron 4MG IV (TDS) for 7 days given and calcium and multivitamin supplementary was given for 7 days to enhance immune function. he was taking all treatment and outcome was good.

No any change in restorative.

Follow-up and Outcomes:

Clinical and patient assessment outcomes: patient condition was improved.

Important check out investigation and other test results: to preventing the progression of disease and trying to reserve any sign and symptoms that has appeared because of treatment to prevent recurrence of the disease. Doctor advised follow up after 1 month a ct scan brain, blood investigation and other examination to know the further disease progression.

Intervention adherence and tolerability: patient took all prescribed medications regularly. but sometime she was refused to take medication. She also followed the dietician advised. Dietician was advised healthy food and rich in calcium and multivitamin supplementation. Her interventional adherence was satisfactory.

Adverse and unanticipated events: no any.

Discussion:

Migraine may be distinguished from other headache disorders because attacks are moderate to severe and present unilaterally with pulsating pain that worsens with exertion or interferes with the ability to be physically active. To be considered migraine, attacks must also present with 1 of the following symptoms: photophobia or photophobia and nausea or vomiting. Some attacks also present with auras—sensory disturbances—preceding or occurring with the onset of the headache. Visual auras, as noted in our case, are the most common. The differential diagnosis also includes cluster headaches and tension headaches. Cluster headaches are marked by assault of intense, Pain in the orbital, supraorbital, and temporal regions that is unilateral. They endure 15 to 180 minutes and follow a cyclic pattern, with nighttime episodes being the most severe. Tension headaches are characterized by bilateral discomfort that feels like pressure or constriction. The discomfort is felt in the temples, stern, and neck. The headaches might last anywhere ranging from 30 minutes to seven days⁴

Admissions to neurology clinics are frequently caused by dizziness and headache. One of these causes is VM. It affects roughly 1% of the general population over their lifetime and 0.9 percent annually. Women are 1.5–5 times more likely than men to have it. Although there is no apparent genetic link, chromosomes 11q and 5q35 have lately been studied for migraine-related vertigo. Clinical symptomatology is used to make the diagnosis of vestibular migraine. As a result; the patients' attacks should be briefly questioned for Diagnosis alternatives. Brain tumors, Benign paroxysmal, and ministroke are all symptoms of basilar migraine. are among the possible diagnoses. Vertigo bouts can be mistaken for migraine aura; however, aura can be recognized by its persistence and relationship to the headache. Vertigo may accompany basilar migraine; nevertheless, migraines headache following a minimum of two posterior circulation findings lasting 5–160 minutes may be present for basilar migraine, according to the ICDH-2 criteria. Furthermore, people with basilar migraine have been shown to have more severe vertigo spells. Meniere's disease is distinguished from VM by pulsatile, progressive hearing loss with vertigo bouts, accompanied by tinnitus and low-frequency hearing loss in the early stages. In addition to the symptomatology similarities between Meniere's illness and VM, Meniere's disease has been observed to be more common in people who had had a migraine in the past. Another differential diagnosis is that in benign paroxysmal vertigo, vertigo attacks last seconds and usually terminate spontaneously within weeks or months, however in VM attacks that last a year, it takes much longer and no spontaneous improvement is expected. Positional VM can usually be separated from benign paroxysmal vertigo by examining positional nystagmus during acute vertigo episodes. The illness known as a transient ischemic attack (TIA) becomes more common as people age. Ischemic attack differs from VM in that it has more neurological symptoms, risk factors, and abnormal doppler ultrasonography than VM.⁵ Related studies were reviewed⁶⁻¹¹.

Conclusion:

Employee capacity is significantly impacted by headache. Both health care professionals and employers play a role in providing appropriate therapy that can assist the majority of migraineurs reduce their symptoms. By implementing comprehensive illness management strategies, employers can lessen the economic burden of migraine on worker capacity. Such programmes should include patient education on lifestyle changes that may reduce the occurrence of visits and intensity of migraines, as well as migraine medicines for early treatment and/or avoidance, if needed. Migraine researchers have the opportunity to improve the quality and comparability of worker productivity data, as well as give decision-makers with more precise information. The impact of such therapy on worker productivity will become more relevant in assessing a company's worth. As more medication options become available to patients and prescribers, the prevalence of such treatments will rise.

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