Idiopathic Abdominal Pain in Children May Be Migraine

**BY MIRIAM E. TUCKER**

**NATIONAL HARBOR, Md. —** Abdominal migraine might be responsible for up to 1% of all cases of idiopathic recurrent abdominal pain in children, according to an analysis of records from more than 400 children.

Abdominal migraine is an idiopathic disorder that is characterized by moderate to severe, episodic, abdominal pain lasting 1-72 hours associated with vasomotor symptoms, nausea, and vomiting. It is recognized by the International Headache Society (IHS) as being among the “periodic syndromes of childhood that are commonly precursors of migraine” (Cephalalgia 2004;24 suppl 1:9-16).

Most of the literature on the topic is from Europe, and the diagnosis is far more common there than it is in the United States, where it is largely undiagnosed, Dr. Laura D. Carson and her associates reported in a poster she presented at the annual meeting of the North American Society of Pediatric Gastroenterology, Hepatology, and Nutrition.

In a retrospective chart study of 600 children and young adults (ages 1-21 years, 59% female) who were referred to a pediatric gastroenterologist during 2006-2007 for recurrent abdominal pain, 23.5% (141) were excluded because of a preexisting diagnosis. Of 458 children who met inclusion criteria, 4% (20) met the IHS diagnostic criteria for abdominal migraine, while another 11% (50) were considered probable diagnoses of abdominal migraine with documentation lacking for at least one diagnostic criterion.

The remaining 85% (388) did not meet the criteria, said Dr. Carson and her associates, of Eastern Virginia Medical School and Children’s Hospital of the King’s Daughters, both in Norfolk, Va.

In an interview, Dr. Carson said no significant relationship was identified among those with abdominal migraine and those who had family histories of either abdominal pain or headache. However, children who met the abdominal migraine criteria were four times more likely to have had a migraine headache themselves.

Despite its inclusion in both the IHS classification as well as inclusion in the 2006 Rome III criteria (Gastroenterology 2006;130:1527-37), abdominal migraine is infrequently considered in the differential diagnosis of recurrent abdominal pain in children. Part of the problem is that expertise in migraine lies with neurologists, who are rarely called upon to evaluate abdominal pain.

Abdominal migraine occurs only in children, whereas in adulthood it presents to neurologists as classic migraine headache. Children with recurrent abdominal pain often are referred to gastroenterologists, who rule out other organic causes but might not consider migraine as an etiology.

“Given the spectrum of treatment modalities now available for pediatric migraine, increased awareness of cardinal features of abdominal migraine by pediatricians and pediatric gastroenterologists may result in improved diagnostic accuracy and early institution of both acute and preventative migraine-specific treatments,” Dr. Carson and her associates said in their poster.

This study was funded by the Children’s Specialty Group Chairman’s Fund, based at Children’s Hospital of the King’s Daughters, Norfolk. Dr. Carson stated that she had no other financial disclosures.

Isocarboxazid Appears to Reduce Migraine Frequency

**BY MICHELE Q. SULLIVAN**

**PHILADELPHIA —** The monoamine oxidase inhibitor isocarboxazid may be an effective migraine preventive as well, Dr. Bruce Corser reported in a poster presented at the International Headache Congress.

Although the open-label trial was small, with just 20 patients, all of those who completed it showed a significant decrease in migraine frequency over 20 weeks, said Dr. Corser, the medical director of Community Research, Cincinnati.

Isocarboxazid is approved for the treatment of depression. “The efficacy of antidepressants and other serotonin-modulating drugs in the treatment of migraine has suggested that monoaminergic pathways are involved in the etiology of migraine,” Dr. Corser wrote. “In addition, a recent study has identified an association between genetic polymorphisms of MAO-A and migraine.”

Dr. Corser and his colleagues included 14 patients (mean age 44 years) who had a diagnosis of migraine and a history of 3-12 migraine headaches per month for the 3 months preceding recruitment. The patients were not allowed concomitant use of antidepressants or other common anti-migraine drugs.

Isocarboxazid was started at 20 mg/day and increased as needed and tolerated to a maximum of 60 mg/day. Most of the patients tolerated a maximum dose of 20-40 mg/day.

However, adverse effects were common and caused five patients to discontinue the trial—one each for insomnia, irritability/anxiety, mood swings/fatigue, anorgasmia, and fatigue. Three other patients reported adverse events as well (fatigue, insomnia, and nosebleed), but they continued the trial. A total of seven patients completed the final follow-up.

At baseline, patients reported an average of five migraines a month. By week 8, there was a significant reduction in frequency. By week 20, the average frequency per month was less than one. All of the patients who completed the trial were considered responders by week 16—that is, they experienced at least a 50% decrease in migraine frequency. Dr. Corser and his colleagues reported at the meeting, which was sponsored by the International Headache Society and the American Headache Society.

“In this trial, isocarboxazid showed very robust clinical efficacy in the prophylactic treatment of migraine attack,” Dr. Corser wrote. In addition to affecting monoaminergic neurotransmission, the drug’s effect on blood pressure and vascular tone might add to its benefit in migraine, he added.

The trial was funded by Validus Pharmaceuticals of Parsippany, N.J., and Oxford Pharmaceutical Services of West Totowa, N.J.