UTILITY OF SYNTHESIS REPERTORY IN THE TREATMENT OF MIGRAINE

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LIST OF ABBREVIATIONS

CGRP – Calcitonin gene - related peptide

CSD – Cortical spreading depression

CT – Computed Tomography

D.M. – Dominant Miasm

EEG – Electroencephalogram

F.M. – Fundamental Miasm

IHS – International Headache society

MRI – Magnetic resonance imaging

MSG – Monosodium Glutamate

TMJ –Temporomandibular Joint

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INTRODUCTION

Migraine is a primary episodic headache disorder characterized by various combinations of neurological, gastrointestinal and autonomic changes. It is a common disorder and is the major cause of absenteeism from work and avoidance of social and personal activities.

The definite cause of the migraine is yet to be known; the condition may result from a series of reactions in the central nervous system due to changes in the body or in the environment. There is often a family history of the disorder suggesting that the migraine sufferers may inherit sensitivity to triggers like alcohol, hunger, lack of sleep, stress, foods that contain caffeine, monosodium glutamate & nitrates and hormonal changes in woman that produce inflammation in the blood vessels & nerves around the brain causing pain.

The physical & neurological examinations as well as laboratory studies are usually normal and serve to exclude other more ominous causes of headache. Though there are many modes of treatment, no method can give satisfactory result in all cases of migraine.

Migraine is a manifestation of constitutional disorder and as such it requires constitutional treatment for its cure. Medicines covering symptoms of headache only may give temporary relief from time to time but a complete cure there by may not be possible unless the Homoeopathic constitutional medicine is prescribed in appropriate doses.

Homoeopathy is a better mode of treatment in such cases, since it can remove the disease in its whole extent in a reliable and the most harmless way. Although the efficacy of homoeopathic medicines in treating migraine are studied in different perspectives, no systematic study has been conducted in this subject in relation to the role of homoeopathic Repertories.

Synthesis a modern repertory is the product of continuous teamwork with superb technology; It is the printed version of RADAR (Rapid Aid to Drug Aimed Research) Computer program. This repertory has set a new standard by adding information and continuous verification by its users.

This study is to facilitate a clear understanding of the applicability of *synthesis* repertory in migraine disorder.

AIMS AND OBJECTIVES

1. Utility of *Synthesis* repertory in treatment of migraine.
2. To study the rubrics related to migraine in *Synthesis* and other main Repertories.

REVIEW OF LITERATURE

HEADACHE

Headache is a term used to describe aching or pain that occurs in one or more areas of the head, face, mouth, or neck. Headache can be chronic, recurrent, or occasional. The pain can

be mild or severe enough to disrupt daily activities. Headache involves the network of nerve fibers in the tissues, muscles, and blood vessels located in the head and at the base of the skull.[55]

The experience of headache has been around as long as the human race. Our ancestors believed that headache was visited upon us as punishment for offending the Gods or that it occurred when humans became possessed by evil spirits. Through the ages treatment has been directed at the suspected cause; not surprisingly, headache remedies were aimed at ridding the body of demons. Thus, the earliest neurosurgeons bored holes in the skull through which the headache-causing demons could escape. Skulls with evidence of such surgery (called trephination) have been found in Peru and date back to the thirteenth century[48]

References to headache are found as far back as 3000BC. The earliest published reference is a Sumerian epic poem, an early description of the sick headache.

The sick-eyed says not

'I am sick eyed'

The sick- headed not

'I am sick headed'

The Ebers papyrus, an ancient Egyptian prescription for headache dating back to about 1200BC, mentions migraine, neuralgia and shooting head pains and is said to be based on earlier medical documents from approximately 1550BC [34]

ANATOMY AND PHYSIOLOGY OF HEADPAIN

The skull, much of the pia-arachanoid and dura over the convexity of the brain, and the parenchyma of the brain, are insensitive to pain. The following cranial structures are sensitive to pain: skin, subcutaneous tissue, muscles, extracranial arteries, periosteum of the skull, intracranial venous sinuses, especially in the pericavernous region, parts of the dura at the base of the brain, arteries with in the dura and pia-arachanoid, the structures of the eye, ear, nasal cavities, and sinuses, and the optic, occulomotor, trigeminal, glossopharengeal, vagus and first three cervical nerves.

The main pathways whereby sensory stimuli are conveyed to the central nervous system are the trigeminal nerves, particularly first and to some extent the second division, which convey impulses from the forehead, orbit, anterior and middle cranial fossa. Superficial structures refer pain locally and deeper structures refer pain to a distant part e.g. Pain of an occipital lobe tumour that lies well towards the back of the head, with in the supratentorial

compartment Which is innervated by the first division of the trigeminal nerve (V1) is referred to the front of the head; Likewise the posterior fossa is innervated by C2 and C3, and with lesions here the pain tends to be referred posteriorly. This mechanism of pain referral is termed "convergence". The perception of pain is further modified by the central nervous system mainly in the caudal nucleus of the trigeminal nerve. Here the nociceptive impulses are met by both inhibitory and facilitatory impulses, which descend from higher structures within the cortex and the brain stem.[33]

When a person has a headache, several areas of the head can hurt, including a network of nerves that extends over the scalp and certain nerves in the face, mouth, and throat. The muscles of the head and the blood vessels found along the surface and at the base of the brain are also sensitive to pain because they contain delicate nerve fibers. The ends of these pain-sensitive nerves, called nociceptors, can be stimulated by stress, muscular tension, dilated blood vessels, and others triggers of headache. Vascular headaches (migraines are a kind of vascular headache) are thought to involve abnormal function of the brain's blood vessels or vascular system; muscle contraction headaches appear to involve the tightening or tensing of facial and neck muscles; and traction and inflammatory headaches are symptoms of other disorders, ranging from brain tumor to stroke to sinus infection. Some types of headache are signals of more serious disorders: sudden, severe headache; headache associated with convulsions; headache accompanied by confusion or loss of consciousness; headache following a blow on the head; headache associated with pain in the eye or ear; persistent headache in a person who was previously headache free; recurring headache in children; headache associated with fever; headache that interferes with normal life.[56]

Where an underlying structural cause is detected, the mechanism of head pain can be explained on the basis of inflammation or traction of pain- sensitive structures. With intracranial expanding lesions such as brain tumour and hydrocephalus, there is traction and displacement of pain- sensitive vessels; with meningitis and sub arachanoid Haemorrhage, there is inflammation of vessels in the meninges; with temporal arteritis and intracranial vasculitis, there is inflammation of the scalp and intracranial vessels and with low intra cranial pressure states such as post-spinal headache, there is sagging of the brain and traction on dural attachments and intracranial dilatation. [33]

CLASSIFICATION OF HEADACHE

Before 1988, the headache classification systems that were available had no operational rules, and nomenclature was anything but uniform. In 1988 the international headache society

(IHS) instituted a classification system that has become the standard for headache diagnosis, particularly for clinical research.

The system identifies 12 major categories of headache, which can be divided into two broad groups, the primary headache disorders and the secondary headache disorders.

In secondary headache disorders the headache is symptomatic of an underlying condition such as a brain tumour, stroke or metabolic state. In primary headache disorders there is no underlying cause; the headache itself is the problem.

IHS classification outlines the four major categories of primary headache: Migraine, Tension type headache, Cluster headache and a miscellaneous group. The eight secondary categories include headache associated with head trauma, vascular disorders, non vascular disorders, substances, non cephalic infection, metabolic disorders, disorders of the face& neck as well as cranial neuralgias. Finally headache that is not classifiable elsewhere.[34]

Headache comes in many different guises, some of the major headache types

1. Migraine
2. Muscle Contraction Headache/Acute Tension Type Headache
3. Chronic Daily Headache
4. Cluster Headache
5. Ice Pick/Ice Cream Headache
6. Sinister Headache: Meningitis/Subarachnoid Haemorrhage/Cranial Arteritis
7. Facial Headache: Acute Sinusitis, Post Herpetic Neuralgia, Trigeminal Neuralgia, Temporomandibular Joint

Migraine is a severe headache type and can have a considerable impact on the daily life of sufferers and affects between 17 per cent of women and 6 per cent of men, although estimates vary. Accurate diagnosis of the different presentations of migraine is the foundation of effective prescribing and management.

Diagnostic pointers for migraine.

1. Attacks last from 4 to 72 hours
2. Patients are usually symptom-free between attacks
3. Headache is at least two of the following

a. Unilateral (on one side)

b. Pulsating

c. Moderate to severe

d. Aggravated by routine activities

4. Accompanying symptoms may include

a. Photophobia (more sensitive to light)

b. Phonophobia (more sensitive to noise)

c. Nausea and Vomiting

Muscle Contraction Headache Type/Acute Tension Headache Type: Muscle Contraction Headache or Acute Tension Headache Type occurs in about 50% of the population on a monthly basis. Typically this headache type is mild to moderate only, non-pulsating and bilateral. Sensory sensitivity to noise or light is more likely to be associated with migraine. Difficulties arise when patients who are suffering from migraine are misdiagnosed as having a tension headache type. Patients often describe the pain as a "feeling of tightness or squeezing". The causes of tension headache type are not known.

Chronic Daily Headache Type: Chronic Daily Headache is defined as a headache type which is present on most days i.e. > 15 days a month, typically occurring over a six-month period or longer and it can be daily and unremitting. In some patients, an episode of chronic headache resolves in a much shorter time. It can occur in children and in the very old. Twice as many men have it compared to women. Many different classifications have been used to describe Chronic Daily Headache including medication misuse headache, hemicrania continua and transformed migraine. Chronic Daily Headache Type is characterised by a combination of background, low-grade muscle contraction-type symptoms, often with stiffness in the neck, and superimposed migrainous symptoms

Cluster Headache Type: Cluster headache is an excruciating condition that is fortunately rare. It affects 1 in 1000 men and 1 in 6000 women; most are in their twenties or older and many are smokers. It is characterised by frequently recurrent, short lasting headache and autonomic symptoms. The episodic form occurs in bouts (clusters), typically of 6-12 weeks duration once a year or every two years and at the same time of year. Strictly unilateral intense pain around the eye develops once or more daily, commonly at night. This headache type is sudden in onset and lasts between 15 -180 minutes and can occur between once a day to eight times a day. The eye is red and waters, the nose runs or is blocked on that side, and ptosis (droopy eyelid) may occur.

Ice Pick/Ice cream Headache Type: Typically the patient is young to middle aged and patients describe a short piercing pain like a flash of lightening lasting from seconds to minutes and may occur several times a day. Ice-Pick headache Type usually involves one eye and bruised after the pain has gone. Some patients find cold foods trigger the pain. Sometimes the patient has multiple attacks per day on a daily basis.

Sinister Headache Type

1. Meningitis: usually accompanied by fever and neck stiffness in an obviously ill patient.
2. Intracranial tumours: produce headache when they are large enough to cause raised intracranial pressure, which is usually apparent from the history. Papilloedema or focal neurological signs, or both, will usually be present. Fortunately these are very rare.
3. Subarachnoid haemorrhage: headache is often described as the worst ever, and is usually (but not always) of sudden or ictal onset. Neck stiffness may take hours to develop. In elderly patients particularly, classic symptoms and signs may be absent.
4. Temporal arteritis: headache is persistent but often worse at night and sometimes severe, in a patient over 50 who does not feel entirely well. It may be accompanied by marked scalp tenderness.
5. Primary angle closure glaucoma: rare before middle age, may present dramatically with acute ocular hypertension, a painful red eye with the pupil midodilated and fixed and, essentially, impaired vision, and nausea and vomiting. In other cases, headache or eye pain is episodic and mild. The diagnosis is suggested if patient reports coloured halos around lights.
6. Idiopathic intracranial hypertension: rare cause of headache; occurs especially with obese young women. May not be evident on history alone; Papilloedema indicates the diagnosis.
7. Sub acute carbon monoxide poisoning: uncommon but potentially fatal. Symptoms include headaches, nausea, vomiting, giddiness, muscular weakness, dimness of vision, and double vision.

Facial Headache Types

Sinusitis is caused by infection of one or more of the cranial (skull) sinuses. The International Headache Society's criterion of purulent discharge and acute febrile illness is indicative of acute sinusitis (sinus headache). The site of the pain varies according to the location of the infection. Maxillary sinusitis pain is mostly in the cheek, gums, teeth and upper jaw. When pain is presented between and around the eyes this is referred to as ethmoidal sinusitis. Frontal sinusitis pain is seen in the forehead and sphenoidal sinusitis presents with pain at the crown of the head. The pain often has a dull aching quality which is worsened by bending.

Post Herpetic Neuralgia Shingles (herpes zoster virus) can cause pain resulting from various cranial nerves. The pain may start during an acute rash of herpes but the main problem is pain that persists after the herpes rash has gone. Common symptoms include a constant deep pain, with repeated stabs, or needle pricking pain. Even light touch can trigger these symptoms which may be accompanied by itching.

Trigeminal neuralgia is considered to be the most common neurological syndrome in the elderly. Women are three times more likely to get it than men. Over 95% of cases are unilateral. The pain is often described as an electric shock or spasm or burning sensation in one or more of the three divisions of the trigeminal nerve. The pain lasts from 2-120 seconds. The ophthalmic division supplies the forehead, eyes and scalp, the maxillary supplies the cheek and the mandibular supplies the lower cheek, lower lip and chin. The condition has been called 'tic douloureux' because the facial muscles may twitch. Patients can sometimes have a dull ache as a continuous symptom. The trigger can be cold air, washing the face or cleaning the teeth. The pain can be excruciating. The most common cause is thought to be vascular compression resulting from abnormal arterial roots near the nerve root. MRI scans can confirm this. Other possible causes include malignancy, multiple sclerosis, intracranial aneurysms and cranial arteritis.

Temporomandibular Joint (TMJ): Each side of the jaw is hinged to the skull and this joint is known as the temporomandibular joint (TMJ). Low grade muscle contraction headache type or migraine can result from temporomandibular joint dysfunction. Possible causes include new dental fillings, which may unbalance the bite, grinding the teeth while asleep (Bruxism) and continued stress during the day can initiate and exacerbate the pain.[46]

MIGRAINE

Migraine is characterized by episodic headache, which is typically unilateral and often associated with vomiting and visual disturbances. In many patients, however the headache is

bitemporal and generalized and there may be no associated focal visual or neurologic disturbance. The single most characteristic feature is episodic nature of headache.[12]

Migraine is a primary episodic headache disorder characterized by various combinations of neurological, gastrointestinal and autonomic changes. Many famous and creative individuals have suffered from migraine. Migraine diagnosis is based on the retrospective reporting of headache characteristics and associated symptoms. The physical and neurological examinations, as well as laboratory studies, are usually normal and serve to exclude other, more ominous, causes of headache.[34]

The term migraine stems from Galen's usage of hemicrania to describe a periodic disorder consisting of paroxysmal blinding hemicranial pain, vomiting, photophobia, recurrence at regular intervals, and relief by dark surroundings and sleep. Hemicrania was later corrupted into low Latin as hemigranea and migraena; eventually the French cognate, migraine, gained acceptance in the eighteenth century and has prevailed ever since.[13]

HISTORY OF MIGRAINE:

Migraine has been described for centuries. Early observations guide us in pursuit of a cause and solution to migraine today. Here are some major stepping stones in the history of migraine: [54]

The Ebers papyrus an ancient Egyptian prescription for headache dating back to about 1200Bc mentions migraine, neuralgia and shooting head pains

Hippocrates- in 400Bc described the visual aura that can precede the migraine headache and its relief by vomiting.[34]

1st century A.D. - *Aretaeus, or Aretaios* the Cappadocian, classified headache into cephalalgia, cephalaea, and migraine. Our modern classifications of headache stem from these roots.

2nd century A.D. - *alenus of* Pergamon used the term "hemicrania", from which the word "migraine" was derived. He thought there was a connection between the stomach and the brain because of the nausea and vomiting that often accompany an attack.

10th century A.D. - For relief of migraine, Spanish-born physician *Abulcasis*, also known as *Abu'l Quasim*, suggested application of a hot iron to the head or insertion of garlic into an incision made in the temple.

12th century A.D.- *Abbess Hildegard* of Bingen gave an account of visions, which may be an early description of migraine prodromes.

Middle ages and

Renaissance. - Followers of *Galenus* explained migraine as caused by aggressive Yellow bile.

Early 17th Century - *Charles le Pois* described premonitory symptoms and migraine with aura for the first time.

1712. *Biblioteca Anatomica, Medic, Chirurgica,* published in London, characterized five major types of headaches, including the "Megrim," recognizable as classic migraine

1780. - *Tissot* suggested that migraine originates in the stomach as a state of irritation that radiates to the supraorbital nerves and triggers the attack. His list of symptoms preceding or accompanying an episode includes nausea and vomiting.

1883. - In the earliest report in medical literature of the use of ergot for the treatment of migraines, *A. Eulenburg* (Germany) used injections of ergot extract and ergotinin in five cases of headache mainly related to the "vasoparalytic form of hemicrania."

1938. - *Graham* and *Wolf* published their paper advocating ergotamine tart for relieving migraine and initiated modern research into migraine

20th century. - The 20th century saw the start of a more scientific approach to migraine study, with controlled migraine drug trials and systematic general research on migraine. The search for the cause continues, but many helpful measures have been discovered along the way [54]

Epidemiology of migraine-

Approximately 10% of the population suffer from migraine (6% males and 15% females) and most do so by the age of 50 years. Males tend to develop it earlier than females, with a preponderance of males over females prior to puberty. However, after puberty approximately three times as many females suffer then men with its prevalence rising to 24% in females around the age of 40.[58]

Age and migraine

It starts before the age of 10 years in about a third of patients. The majority of the patients have their first attack of migraine before the age of 30 years.[35]

Approximately 20% of children under the age of 10 will suffer from migraines and this independent of gender. Many young children (who often have a family history of migraine) have periodic attacks of abdominal pain accompanied by nausea and vomiting. These may turn into typical migrainous episodes as they become older. However, most people develop migraines whilst in their early teens, particularly girls. There is also an association between motion sickness in childhood and migraines later on in life.

Individuals who suffer actively from migraine tend to have a median of 1.5 attacks per month. But at least one migraine sufferer in ten will have a weekly attack. Each attack lasts an average of just under one day. However, about 20% of migraine sufferers have attacks lasting for as long as 2 to 3 days.[58.]

GENETICS OF MIGRAINE.

The familial aggregation of migraine was first noted by tissot in 1970. Since then, numerous studies have examined the transmission of migraine within families, the concordance for migraine among twins, and the linkage of migraine to particular chromosomal loci. With the demonstration of a genetic locus for familial hemiplegic migraine (FHM) on chromosome 19 and the discovery of a candidate gene product from that locus, the study of migraine genetics has truly entered the molecular era.[34]

Further evidence for a genetic component in migraine has received support from studies on identical or fraternal twins; between 40-50% of the tendency to develop migraine is attributable to genetic factors. It is thought that a small number of genes contribute to migraine, some of which are involved in the development of aura symptoms. There are a subset of patients who suffer from migraine with motor auras and these migraines tend to last for several days. This condition can be inherited as an autosomal dominant disorder. In most of the families studied, the genes have been mapped out to the long arm of chromosome 19.[58]

Table No .1: List of common Migraine triggers

Common Migraine Triggers[44]	
Foods	Medications
• Aged cheese • Alcohol (particularly red wine and champagne)	• Vasodilators (nitroglycerin, isosorbide dinitrate) • Hormones (oral contraceptives,

• Monosodium glutamate (contained in seasonings and processed foods) • Chocolate • Nuts, oranges, and tomatoes • Caffeinated beverages • Nitrates and nitrites (hot dogs, sausages, luncheon meats) • Avocado • Smoked or pickled fish or meats • Onions • Aspartame (dietary sweetener) • Yeast or protein extracts (brewer's yeast, marmite) <u>Others</u> • Weather changes • High altitude (air travel, mountain climbing)	estrogens, clomiphene, danazol) • Anti-hypertensives (nifedipine, captopril, prazosin, reserpine, minoxidil) • Histamine-2 blockers (cimetidine, ranitidine) • Antibiotics (trimethoprim-sulfa, griseofulvin) • Selective Serotonin Reuptake • Inhibitors <u>Lifestyle</u> • Fasting or skipping meals • Sleep (too little or too much, changes in patterns, e.g., jet lag, • shift changes) • Letdown following stress (weekends, vacations, after exams) • Caffeine withdrawal

Stress

Stress and perhaps more commonly, the cessation of stress may bring on migraines. The pharmacological basis of this is poorly understood. Moskowitz implicated parasympathetic pathways in the pathogenesis of migraine. It is thought that as the individual relaxes; the parasympathetic nervous system becomes progressively more dominant, resulting in headache. Conversely therefore, headache is suppressed by the activity of the sympathetic nervous system.[58]

Diet

It seems that whilst trigger factors can be identified in precipitating migraine attacks, it does not necessarily follow that these will always precipitate an attack. For example, chocolate, cheese and citrus fruits are the foods most strongly associated with triggering migraines. Whilst most individuals are sensitive to all three foods and a few to only one, there are few patients whose migraines are always triggered by these foods. Patients tend to have spontaneous attacks

even while assiduously avoiding these trigger factors. Many people are also sensitive to alcoholic drinks. This may be to alcohol in general or specific drinks such as red wine.

A number of different theories as to how diet precipitates migraine have been proposed. However, numerous investigations have come up with no clear answer.

Fasting and hypoglycemia

Studies on subjects who have gone without food (and only drunk fluids such as water and tea or coffee without milk) have indicated that fasting may be implicated in precipitating migraine attacks.

Specific agents

It was speculated that tyramine (an indirectly acting sympathomimetic amine) may be responsible for precipitating migraines. It is present in strong cheeses such as Stilton and blue cheese, and in red wine. In experiments where tyramine was ingested, headaches were produced in sensitive individuals. Not having the right enzymes to detoxify these chemicals may be to blame for some people's migraines. However, tyramine is not present in all implicated foods. Monosodium glutamate (MSG) has also been implicated in migraine. This substance is used in many canned foods and sauces, as well a range of pre-packaged convenience foods and in restaurants to add flavour and taste.

Pharmacodynamic tests

Results have shown that some patients have deficiencies in enzymatic pathways for the detoxification of substances such as tyramine. For example, attacks following red wine may be due to the absence of the enzyme phenolsulphotransferase which usually deactivates phenols.

Immunological studies

An immunological basis for migraine seems unlikely. In studies where the level of circulating immunoglobulin G and immunoglobulin E were measured in diet-sensitive patients with migraine, there were no abnormalities in the level of these antibodies. Skin tests have yielded a similar result.

Direct action

Current research indicates that substances such as tyramine may have a direct pharmacological effect on the brain. Neurotransmitters such as serotonin may be directly affected. [58]

Oestrogen

1. Menstrual cycle

There is considerable evidence that migraines are triggered by a fall in oestrogen levels. This coincides with the time just before or at the time of menstruation. This has been borne out in studies where many women confirm that their migraines do occur at this time. Generally, migrainous episodes tend to improve during pregnancy. This is especially true after the first trimester when hormone levels become more stable. However, migraines can then return as early as one week after birth, when oestrogen levels fall rapidly

2. The Pill

The combined contraceptive pill may often worsen migraines. This is once again because relatively high levels of oestrogen are maintained for three weeks each month and then fall rapidly to ensure that the menstrual period can take place. Furthermore, epidemiological evidence has indicated that there is an association between this Pill and stroke in women who have migraines that are preceded by an aura. Smoking is thought to exacerbate this risk

3.Hormone replacement theraphy

Many women find that migraines may become worse during the time of the menopause. This is due to falling oestrogen levels. However, some percutaneous formulations of HRT may worsen rather than improve migraines [58]

DESCRIPTION OF THE MIGRAINE ATTACK

The migraine attack can be divided into four phases: the prodrome phase, which occurs hours or days before the headache; the aura phase, which immediately precedes the headache; the headache phase itself; and the headache resolution phase.

1.Prodrome (premonitary phenomena)

Premonitory phenomena occur in about 60% of migraineurs, often hours to days before headache onset. Usually patients describe a characteristic change in mood or behaviour which may include psychological, neurological, constitutional or autonomic features. Some people simply report a poorly characterized feeling that a migraine attack is coming. While the prodromal features are quite variable among individuals, they are rather consistent within a individual. The prodrome is common. It occurs in equal frequency in migraine with and without aura.

Table No.2: Prodromal (premonitory Phenomena) symptoms of migraine

Mental state	Neurological	General
Depressed	Photophobia	Stiff neck

Hyperactive Euphoric Talkative Irritable Drowsy Restless	Difficulty concentrating Phonophobia Dysphasia Hyperosmia Yawning	Food cravings Cold feeling Anorexia Sluggish Diarrhoea or Constipation Thirst Urination Fluid retention

2.Aura

The migraine aura is a complex of focal neurological symptoms which precedes or accompanies an attack. Most aura symptoms develop over 5-20 minutes and usually less than 60 minutes. The aura can be characterized by visual, sensory, or motor phenomena, and may also involve language or brainstem disturbances

Headache usually occurs within 60 minutes from the end of the aura but may not occur for several hours if at all. The headache may begin before or simultaneously with the aura, or the aura may occur alone. Patients can have more than one type of aura, with the progression from one symptom to another.

Auras vary in their complexity, Elementary visual disturbances include scotoma, simple flashes (phosphenes) specks or geometric forms. These minor visual disturbances are more likely to occur during than before the headache. More complicated auras include teicopsia (Greek for 'town wall and vision) or fortification spectrum, the most characteristic visual aura of migraine. An Arc of scintillating lights, usually but not always beginning near the point of fixation, may form into a herring bone-like pattern that expands to encompass an increasing portion of a visual field. It migrates across the visual field with a scintillating edge of often zigzag, flashing or occasionally coloured phenomena.

Visual distortions & hallucinations can occur, commonly in children, are usually followed by a headache and are characterized by a complex disorder of visual perception that may include metamorphopsia, micropsia, macropsia, zoom vision (opening up & closing down in the size of objects) or mosaic vision (fracture of image into facets). In addition, non-visual association cortex symptoms occur and include: complex difficulties in perception and use of the body (apraxia and agnosia); speech and language disturbances; states of double or multiple consciousness associated with déjà vu or jamais vu; elaborate dreamy, nightmarish, trance like or delirious states.

Paresthesias, the second most common aura, typically are often cheiroaural, with numbness starting in the hand migrating up the arm, and then jumping to involve the face, lips and tongue. The leg is occasionally involved. As with visual auras Paresthesias may be followed by numbness and, in a few cases, loss of position sense. Sensory auras rarely occur in isolation and usually follow a visual aura.

Motor symptoms can occur in up to 18% of patients, most often in association with sensory symptoms; however true weakness is rare and is always unilateral. Sensory ataxia is often reported as weakness; hyperkinetic movement disorders, including chorea have been reported. Aphasic auras (speech abnormalities) including aphasia have been reported in 17-20% of patients.

3.Headache phase

The typical headache phase of migraine is unilateral, throbbing, moderate to marked in severity and aggravated by physical activity. Pain may be bilateral (in 40% cases) or start in one side and become generalized The headache of migraine can occur at any time of the day or night , but it occurs most frequently on arising in the morning. The onset is usually gradual; the pain peaks and then subsides, and usually lasts between 4 to 72 hours in adults and 2 to 48 hours in children.

The pain of migraine is invariably accompanied by other features. Anorexia is common, although food craving can occur. Nausea occurs in almost 90% of patients, while vomiting occurs in one-third of migraineurs. Many patients experience sensory hyprexcitability manifested by photophobia, Phonophobia and osmophobia, and seek a dark, quite room. Other systemic symptoms, including blurry vision, nasal stiffness, anorexia, hunger, tenesmus, diarrhoea, abdominal cramps, polyuria (followed by decreased urinary out put after the attack), pallor (or, less commonly redness) of the face, sensation of heat or cold, and sweating, may be noted during the headache phase. There may be localized oedema of the scalp, the face or under the eyes, tenderness of the scalp,

Unusual prominence of a vein or artery in the temple, or stiffness or tenderness of the neck. Impairment of concentration is common; less often there is memory impairment. Depression, fatigue, anxiety, nervousness and irritability are common. Light headedness rather than true vertigo, and a feeling of Faintness may occur. The extremities tend to be cold and moist.

4.Resolution phase.

In the termination phase, the pain wanes. Following the headache, the patient may feel tired, washed out, irritable and listless and may have impaired concentration, scalp tenderness or mood changes. Some people may feel refreshed or euphoric after an attack, while others note depression and malaise.[34]

Frequency of migraine attack:

Migraine is less common before puberty, but cyclical vomiting & travel sickness are common in children who subsequently develop migraine.

The frequency of attacks varies enormously, in a few they may occur two or three times a week, whereas the others may have only one or two attacks in a life time, one or two attacks a month is a common pattern.

They may be more frequent at the time of menstruation and commonly diminish in frequency during pregnancy. The general pattern is towards reduction in frequency with age and sometimes the headache disappears leaving only an aura.[41]

TYPES OF MIGRAINE

IHS MIGRAINE CLASSIFICATION [34]

1. Migraine

1.1 Migraine without aura

1.2 Migraine with aura

1.2.1 Migraine with typical aura

1.2.2 Migraine with prolonged aura

1.2.3 Familial hemiplegic migraine

1.2.4 Basilar migraine

1.2.5 Migraine aura without headache

1.2.6 Migraine with acute onset aura

1.3 opthalmoplegic migraine

1.4 Retinal migraine

1.5 childhood periodic syndromes that may be precursors to or associated with migraine

1.5.1 Benign paroxysmal vertigo of childhood

1.5.2 Alternating hemiplegia of childhood

1.6 complications of migraine

1.6.1 Status migrainosus

1.6.2 Migrainous infarction

1.7 migrainous disorders not fulfilling above criteria.

MAJOR TYPES OF MIGRAINE

There are several types of migraine, all share basic features, and each person will suffer this headache in a unique way. Generally, however, migraine often begins as a dull ache and then develops into a constant, throbbing and pulsating pain felt at the temples, as well as the front or back of one side of the head. The pain is usually accompanied by nausea and vomiting, and sensitivity to light and noise.

The two most prevalent types of migraine are migraine with aura (formerly referred to as classic migraine) and migraine without aura (formerly referred to as common migraine). "Classic migraine" is distinguished from "Common migraine" by Visual or neurological symptoms during the half hour before the headache.[3]

Migraine without Aura

Migraine is a vascular headache, which means the headache is associated with changes in the size of the arteries inside and around the skull. During the pre-headache phase, blood vessels constrict; when vascular dilation occurs, the migraine begins. The blood vessels are thought to become inflamed as well as swollen, and it is believed that migraine pain is caused by this inflammation, as well as by the pressure on the swollen walls of the blood vessels.

Most migraine sufferers experience two to four headaches per month; but, some people can get one every few days, and others may only have one or two a year. Most migraine headaches last at least four hours, although very severe ones can last up to a week. Headaches may begin at any time of the day or night; and while a sufferer may wake up with one, a migraine will rarely awaken a person from sleep.

Approximately one-third of migraine sufferers experience an aura prior to the headache pain.

Migraine with Aura

While most migraine sufferers experience visual problems during the headache, some migraine begins with an aura, a manifestation of neurological symptoms. Generally, the aura begins from five to thirty minutes before the actual onset of the headache. You may see wavy or jagged lines, dots or flashing lights; or, you experience tunnel vision or blind spots in one or both eyes. The aura can include vision or hearing hallucinations and disruptions in smell (such as strange odors), taste or touch. It can become even more disconcerting or frightening if it involves feelings of numbness, a "pins-and-needles" sensation or even difficulty in recalling or

speaking the correct word. These neurological events may last sixty minutes and will fade as the headache begins.

Hemiplegic Migraine

The hemiplegic migraine often begins with temporary motor paralysis and/or sensory disturbances on one side of the body, followed by the headache, within the hour, which may be accompanied by numbness or the "pins and needles" sensation. When the headache appears, the initial neurological symptoms may disappear.

Ophthalmoplegic Migraine

Also a rare and severe migraine, the ophthalmoplegic migraine's pain usually surrounds the eyeball and lasts from a few days to a few months. There may be paralysis in the muscles surrounding the eye.

Retinal Migraine

Another rare migraine, the retinal type starts with a temporary, partial, or complete loss of vision in one eye. It is followed by a dull ache behind that eye that may spread to the rest of the head.

Basilar Artery Migraine

This very rare form of migraine is accompanied by dizziness, confusion or lack of balance. It comes on suddenly and can result in fleeting visual disturbances, the inability to speak properly, ringing in the ears, and vomiting. Throbbing occurs in the back of the head. The basilar artery migraine is strongly related to hormonal influences and primarily strikes young adult women and adolescent girls; as sufferers age, the migraine with aura may replace the basilar artery type.

Abdominal Migraine

It is difficult to diagnose this migraine because the pain is felt in the abdomen. Nausea, vomiting and diarrhea may occur, and the pain usually occurs in the middle of the abdomen. The attack typically lasts hours and occurs mostly in children as a forerunner of migraine.[47]

Benign paroxysmal vertigo of childhood: This condition is probably not a true migrainous disorder. It is characterized by brief episodes of vertigo, disequilibrium (poor balance), and nausea. Children with this problem are usually aged 2-6 years. Nystagmus may occur during but not between attacks. Hearing loss, tinnitus, or loss of consciousness does not occur, and symptoms usually last only a few minutes. Children with benign paroxysmal vertigo often develop a more common form of true migraine as they mature.[45]

Childhood migraine.

Migraine in childhood is perhaps best characterized as short, sharp, and vicious. The onset is usually very sudden and often characterized by pallor, nausea and vomiting, with occasional complaints of blurred vision.

In some instances giddiness with true vertigo may dominate the picture, and in others the abdominal pain the attacks may be extremely brief, as often as short as 15-20 minutes, with sudden and complete recovery.[27]

Migraine following head injury.

A trouble some migraine variant occurs in a child or adolescent who, after a trivial head injury, may lose sight, suffer severe headache, or be plunged into a state of confusion, with belligerent and irrational behavior that lasts for hours or several days before clearing. In another variant there is an abrupt onset of either one sided paralysis or aphasia after virtually every minor head injury, but with out visual symptoms and little or no headache. although a family history of migraine is frequent in such cases, there has been no hemiplegia in other family members.[39]

Migraine variants

The commonest form of migraine is characterized by headache alone or preceded or accompanied by the visual or sensory symptoms, less often, the visual or sensory symptoms, motor weakness, or language disturbance can occur with out headache ("***Migraine equivalents***"). There is usually a history of classical migraine to assist diagnosis, but occasionally these can occur without any previous history; this is most common in later life, particularly in post menopausal women.[41]

Complications of migraine.

Occasionally patients develop very frequent attacks, and ultimately the migraine, with a recurring or persistent aura, may last for many days with little or no relief (***Status migrainosus***). Dehydration and fatigue may be secondary contributing factors. Rarely, a permanent hemi paresis may develop or persistent in cases of Hemiplegic migraine; similarly a hemianopia may persist and, less commonly, may be associated with prolonged positive visual phenomena. In these instances CT scan evidence of ***ischaemic infarction*** is found.

An association between migraine and epilepsy has been found in some studies, and occasionally an epileptic attack may occur at the height of a severe attack of migraine.[41]

PATHOPHYSIOLOGY

Several theories on the pathogenesis of migraine exist. A clinically relevant model of migraine pathophysiology may explain several phenomena that both clinicians and patients have noted:

- Dietary, sleep, and hormonal changes can trigger a migraine.
- Migraine has a circadian rhythm similar to several diseases of vasoconstriction, such as myocardial infarction, angina pectoris, and ischemic stroke.
- Sleep is effective in aborting many migraines.
- Cerebral blood flow is decreased during migraine aura.
- Both generalized systemic vasoconstriction and local cerebrovascular vasodilation occur on the side where head pain occurs.
- Platelets release serotonin during a migraine attack.
- Levels of calcitonin gene-related peptide (CGRP), and probably substance P, are elevated during a migraine attack.

Some migraine models use the following concepts to explain the above phenomena.

1. Similar to other internal organs, the brain has a pain system to signal tissue injury. The trigeminovascular system acts as a warning system, causing migraines to help "protect" the brain against insults such as ischemia, toxins, and intrinsic disease, just as angina pectoris "protects" the heart against ischemia.
2. Neuronal and chemical activators – including prostaglandins, serotonin, and histamine – can stimulate the trigeminal nerve. Migraine triggers work either directly to alter these chemical mediators (e.g., fluctuating estrogen levels altering prostaglandins during menses), or indirectly through neural mediators (e.g., rapid eye movement [REM] sleep eliminating serotonin release from the dorsal raphe nucleus).
3. When stimulated, the trigeminal nerve releases substance P and CGRP into dural and meningeal blood vessels. The release of substance P causes the degranulation of mast cells and the attraction of polymorphonuclear leukocytes. This leads to mast cell release of histamine and platelet release of serotonin, with consequent vasodilation and exudation of plasma into the tissues. The resulting inflammation and swelling of the blood vessels represents the so-called sterile arteritis that H. Wolff described half a century ago.

4. The neurogenic inflammation and release of substance P causes both distention of cranial arteries and headache pain. It is likely that nitric oxide mediates the vasodilation and may also act as a nociceptive neurotransmitter.

5. Trigger factors either have direct actions on vasomotor tone (e.g., tyramine in certain foods) or mediate neurochemical release (e.g., sleep alters serotonin release from the dorsal raphe nucleus; stress modifies catecholamine levels). Platelet changes, neurochemical mediators, and ischemia can also trigger the trigeminovascular system.

6. Increases in platelet activity and catecholamine levels and in serotonin release from the dorsal raphe nucleus occur in the early morning. Because these changes may trigger the trigeminovascular system, either directly or through ischemia, this might at least partially explain the circadian rhythm of migraine.

7. REM sleep inhibits the release of serotonin from the dorsal raphe nucleus, and sleep may abort a migraine attack by inhibiting the serotonin-mediated stimulation of the trigeminovascular system.

Common Theories of Migraine Pathogenesis

Theories on the pathogenesis of migraine include:

- The vascular theory
- The cortical spreading depression theory
- The neurovascular hypothesis
- The serotonergic abnormalities hypothesis
- The integrated hypothesis.

The Vascular Theory

H. Wolff developed the vascular theory of migraine pathogenesis during the 1940s and 1950s. According to this theory, migraine is a vasospastic disorder that is initiated by vasoconstriction in the cranial vasculature. The vasoconstriction stage appears to be associated with migraine aura.

Following the early vasoconstrictive stage, intracranial or extracranial blood vessels dilate. Whereas most of the brain is insensitive to pain, meningeal blood vessels show a high level of innervation. Thus, blood vessel dilation activates the trigeminal sensory nerves that surround the meningeal blood vessels, causing pain. Activation of trigeminal nerves also causes the release of vasoactive neuropeptides that further contribute to dilation and worsen pain.

Studies have documented the occurrence of oligemia during the aura phase of a migraine, and an increase in blood flow during the headache phase. Moreover, when a patient with a headache is given a vasodilator such as a nitrate, the headache intensifies, whereas when a patient is given a vasoconstrictor such as a 5-HT agonist, the headache is usually alleviated. These studies lend support to the vascular theory.

The Cortical Spreading Depression Theory

Cortical spreading depression (CSD) is a relatively short-lasting wave of depolarization that spreads across the surface of the brain, moving from the back (occipital region) of the cerebral cortex toward the front at about 3-5 mm/minute.This electrical phenomenon can be induced in animals with noxious stimuli, and is frequently referred to in the literature as the "spreading depression of Leao."

According to the theory, CSD begins with a brief wave of excitation, followed by a prolonged period of neuronal depression, which is associated with disturbances in nerve cell metabolism and regional reductions in blood flow. It has been suggested that migraine aura results from this spreading depression that suppresses neuronal activity as it passes forward over the cerebral cortex. During migraine without aura, cerebral blood flow abnormalities usually are not seen, but recent data suggest that this may not always be the case.

Although CSD has been demonstrated only in animals, support for the CSD theory comes from observations that, in patients who have migraine with aura, a gradual spread of reduced blood flow that mimics the rate of progression of CSD in animals can be measured during the aura phase. One researcher who mapped his own scintillation scotomas noticed a relationship between the development and spread of the visual disturbance and the organization of the visual cortex of the brain. Thus, the aura symptoms were consistent with a wave of intense excitation developing in the visual cortex, followed by a longer period of inhibition.

The Neurovascular Hypothesis

Fibers from the trigeminal nerve innervate blood vessels in the meninges, the extracranial arteries, and those in the circle of Willis. These nerve fibers contain nociceptors

that are capable of generating pain impulses, and the endings of these nerve fibers contain peptide neurotransmitters

The neurovascular hypothesis proposes that either migraine triggers or CSD can activate trigeminal nerve axons, which then release neuropeptides (such as substance P, neurokinin A, and CGRP) from axon terminals near the meningeal and other blood vessels. Substance P and neurokinin A cause vasodilation and promote the extravasation of plasma proteins and fluid from nearby meningeal blood vessels. Although CGRP does not promote plasma extravasation, it is a potent vasodilator. Together, these neuropeptides produce an inflammatory response in the area around the innervated blood vessels. This response is termed sterile neurogenic perivascular inflammation.

The neuropeptides may also sensitize nerve endings, providing a mechanism for sustaining the headache. When activated, the trigeminal nerve also transmits pain impulses to the trigeminal nucleus caudalis, which relays pain impulses to higher centers of the brain.

According to the neurovascular theory, vasodilation is not the cause of migraine headaches but is an accompanying phenomenon attributable to trigeminal nerve activation. Although the cause of this activation is not known, it may be due to ionic and metabolic disturbances in brain function, such as those associated with CSD. It has also been proposed that abnormal activity in brain stem sensory nuclei may cause antidromic activation of trigeminal sensory pathways.

The Serotonergic Abnormalities Hypothesiss

Observations that both plasma and platelet levels of serotonin fluctuate during a migraine attack suggest that serotonin may be involved in the pathogenesis of migraine. When platelets are activated, they aggregate and release serotonin, thus increasing the plasma serotonin level. An increase in plasma serotonin level would be expected to cause vasoconstriction, whereas a decrease in serotonin would promote vasodilation.

Platelet serotonin levels may drop precipitously during the headache phase of migraine. Also, urine levels of serotonin and its metabolites rise during headaches, suggesting that there is a large release of serotonin during such attacks. Moreover, drugs such as reserpine that cause the release and depletion of serotonin from tissue storage sites may precipitate migraine headaches.

An initial surge in plasma serotonin levels may cause constriction of cerebral blood vessels and a reduction in cerebral blood flow. If the blood flow is sufficiently reduced, migraine

aura may result. A subsequent depletion and drop in serotonin levels may then lead to a marked dilation of extracranial and intracranial arteries, precipitating migraine pain.

One brain stem structure that has a high concentration of serotonin receptors is the dorsal raphe nucleus. This nucleus contains many serotonin-secreting neurons that terminate on cerebral blood vessels and various other brain areas that are involved in the production of migraine symptoms. It has been suggested that the raphe nucleus, which is responsive to changes in serotonin levels, may serve as a "migraine generator."

The Integrated Hypothesis

The integrated hypothesis of migraine pathogenesis is an attempt to consolidate various theories and explain several observations related to migraine pain. According to this theory, triggers such as stress, glare, noise, the patient's internal clock, the dilation of the internal or external carotid arteries, or other factors may activate specific centers in the brain stem. One such center, the locus ceruleus, causes changes in epinephrine levels. Another center, the dorsal raphe nucleus, affects serotonin levels in the brain.

Constriction of cerebral blood vessels may cause a localized deficiency in blood flow, provoking CSD, which may, in turn, stimulate trigeminovascular fibers, eliciting neurogenic inflammation and headache pain.

Nerve fibers from the locus ceruleus, the dorsal raphe nucleus, and the trigeminal nerve cause a stimulation of cranial nerves that dilate both cerebral and extracranial blood vessels. The dilation of meningeal vessels contributes to pain generation.

The locus ceruleus also sends fibers to higher centers of the cerebral cortex, where it influences a person’s state of arousal and awareness, and descending projections interact with the body’s pain control mechanisms.

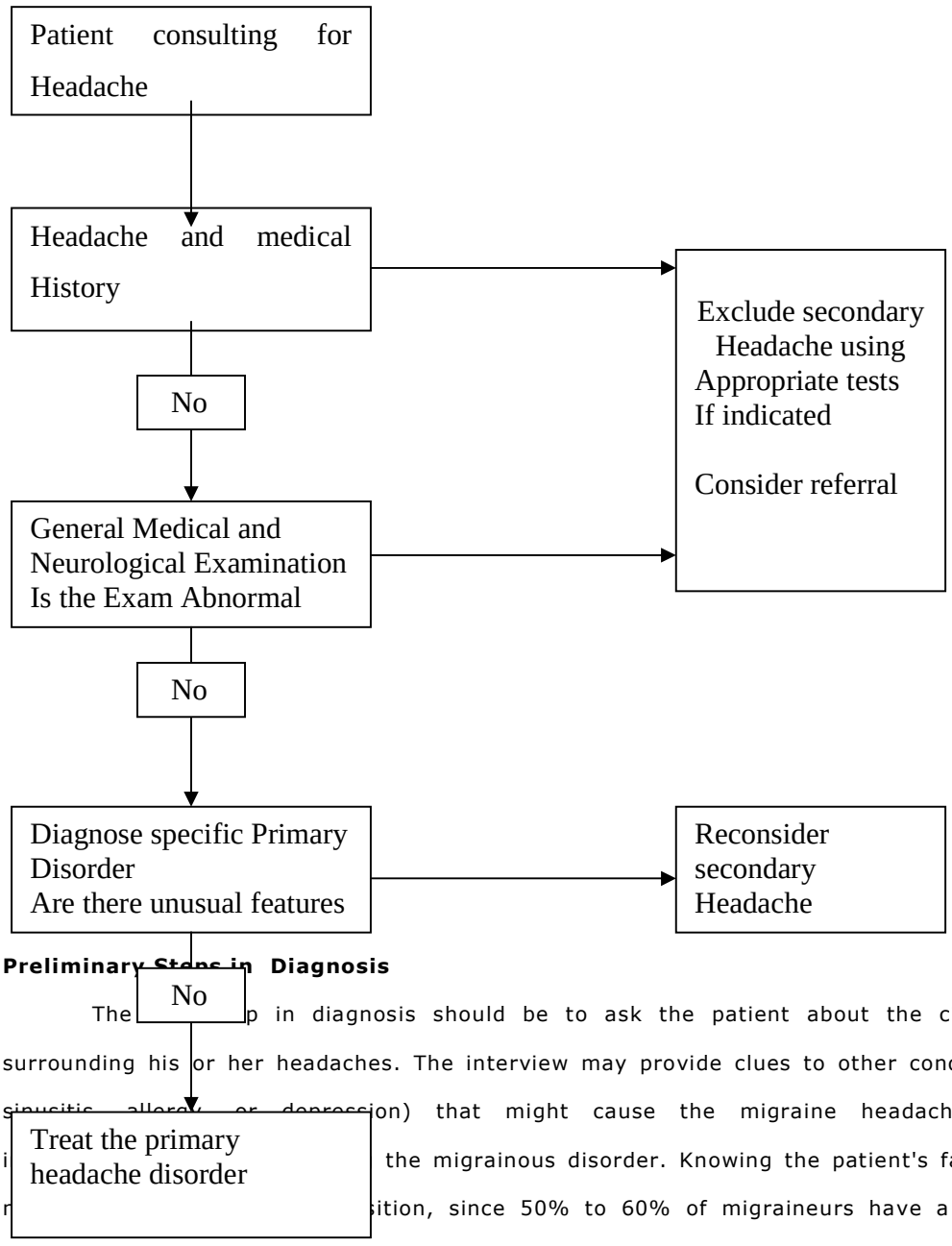
Likewise, the dorsal raphe nucleus sends multiple fibers to blood vessels and upward toward the cerebral cortex. These serotonin-secreting fibers help regulate sleep and neuroendocrine functions. Other connections are made with lower brain stem areas and with the hypothalamus.

A disruption in the normal function of the hypothalamus may be responsible for prodromal signs and symptoms of migraine such as mood changes, food cravings, drowsiness, thirst, and yawning. These signs and symptoms may occur several hours, or even as long as 1 day, before headache pain begins.[53]

DIAGNOSIS

Headache diagnosis is based on complete and through history supplemented by general physical and neurological examination [34]

Figure No.1, Core Algorithm for Headache Diagnosis[34]



Preliminary Steps in Diagnosis

The first step in diagnosis should be to ask the patient about the circumstances surrounding his or her headaches. The interview may provide clues to other conditions (e.g., sinusitis, allergy, or depression) that might cause the migraine headache or occur in association with the migrainous disorder. Knowing the patient's family history may help in diagnosis, since 50% to 60% of migraineurs have a parent with migraine. It is also useful to know when patients had their first attacks, since over 90% of migraineurs experience an attack before the age of 40. Initial onset of attacks after the age of 55, especially in association with other changes (malaise, myalgia, and arthralgia) should raise suspicions of organic causes. Underlying pathology may be suspected if pain is bilateral or always occurs on the same side of the head. Frequency and duration of episodes are significant.

Migraine attacks last from 4 to 72 hours and do not occur daily, so shorter or more frequent attacks tend to rule out migraine. About 50% to 80% of migraineurs have a Prodrome (premonition that an attack will begin in a matter of hours). Prodrome symptoms can be vague and may include hard-to-define symptoms such as yawning, fatigue, food cravings, mood changes, mental vagueness, and fluid retention.

Migraine without aura and migraine with aura are the two main clinical subtypes. Other subtypes include basilar artery migraine (which occurs mainly in adolescent and young adult women and is influenced by the menstrual cycle), opthalmoplegic migraine (in which the headache is concentrated around the eye and is associated with vision problems), and status migrainosus (a rare form that can last longer than 72 hours and produce pain so severe that the sufferers are hospitalized).[55]

History

In evaluating a headache patient the first task is to identify exclude secondary headache based on the history, and the general medical as well as the neurological examinations [34]

A meticulous history is essential in assessing any headache patient. The following headache information should be elicited: [44]

Table. No: 3; Head ache information to be elicited

• age of onset; • family history; • site or sites of pain; • duration; • character; • intensity; • mode of onset; • time between onset to peak pain; • temporal profile; • aggravating or precipitating factors; • alleviating factors;	• associated neurologic, ophthalmologic and autonomic features; • prior and current medication use, including dosage, schedule, and efficacy caffeine use; • history of head trauma; • results of prior Neuroimaging studies; • a complete review of systems; and why the patient is currently seeking medical attention.[32]

Once secondary headaches are excluded, the task is then to diagnose one (or more than one) specific primary headache disorder. In the initial evaluation, the physician looks for 'headache alarms' that suggest the possibility of a secondary headache disorder.

Table.No.4, Diagnostic alarms in the evaluation of headache disorders;

Headache alarm	Differential diagnosis	Possible work up
Headache begins after the age of 50 years.	Temporal arteritis, Mass lesion	Erythrocyte sedimentation rate, Neuroimaging
Sudden-onset headache	Sub arachanoid Haemorrhage, pituitary apoplexy, bleed into a mass or AVM, mass lesion (especially posterior fossa)	Neuroimaging, lumbar puncture.
Accelerating pattern of headache	Mass lesion, sub dural haematoma, medication over use.	Neuro imaging, drug screen
New onset headache in a patient with cancer or HIV	Meningitis(chronic or carcinomatous) brain abscess (including toxoplasmosis) metastasis	Neuro imaging, lumbar puncture
Head ache with systemic illness (fever, stiff neck, rash)	Meningitis, encephalitis, Lyme disease, Systemic infection, collagen, vascular disease.	Neuroimaging, lumbar puncture, Blood tests
Focal neurological symptoms or sign of disease (other than typical aura)	Mass lesion, arteroiovenous malfunction, stroke, collagen vascular disease (including anti phospholipid antibodies)	Neuro imaging, collagen vascular evaluation.
Papilloedema	Mass lesion, pseudo tumour, meningitis	Neuro imaging lumbar puncture

Recent studies have demonstrated that computed tomography (CT) and magnetic resonance imaging (MRI) of the head have extremely low yields in headache patients in the absence of 'alarms'. [34]

The recognition of migraine has been enhanced by the introduction of diagnostic criteria for both migraine with and without aura (formerly known as "classic" and "common" migraine, respectively) by the International Headache Society (IHS). [44]

International Headache Society Criteria for Migraine without Aura [44]

A. At least 5 attacks that fulfill criteria in B, C, D, and E

B. Headache attacks that last 4 to 72 hrs (untreated or unsuccessfully treated)

C. Headache has at least 2 of the following characteristics:

1. Unilateral site

2. Pulsating quality
3. Moderate to severe intensity
4. Aggravation by walking stairs or similar routine physical activity

D. During headache, at least 1 of the following symptoms:

1. Nausea or vomiting (or both)
2. Photophobia and phonophobia
3. No evidence of related organic disease

International Headache Society Criteria for Migraine with Aura [44]

A. At least 2 attacks that fulfill criteria in B and C

B. At least 3 of the following 4 characteristics:

1. One or more completely reversible aura symptoms that indicate focal cerebral cortical or brain-stem dysfunction (or both)
2. At least one aura symptom develops gradually over >4 min or two or more symptoms occur in succession
3. No aura symptom lasts >60 min
4. Headache follows aura in <1 hr

C. No evidence of related organic disease

EXAMINATION.

The main goal of examination is to consider structural brain disease. It also provides an opportunity to screen for co-morbid disease such as hypertension and depression (neither of which commonly cause headaches), and to reassure the patient, their family

The "full neurological examination" is not possible in the time available in primary or routine secondary care, nor is it often necessary.[52]

Besides a neurological examination, a routine general examination, a routine general examination should also be included. Routine vital signs in patients with headache can help exclude causes like hypertension, Meningitis, or systemic febrile illnesses.

Some additional examination may be necessary in headache patients. It may be necessary to palpate over the head and neck for detection of tender trigger-point, to auscultate over the skull, over the carotid and vertebral vessels, to evaluate the temporomandibular joint for tenderness and movement limitations, to palpate the cervical spine for tenderness and movement limitations, to palpate the temporal artery pulsation for arteritis, to examine the extracranial structures.

INVESTIGATION

Certain features in the history or examination raise the suspicion of ominous disease and these situations warrant further investigation. This could also be termed as the 'headache danger signals' and include sudden onset of a new severe headache, a progressively worsening headache or change in the pattern of the headache, onset of headache with exertion such as sexual activity, coughing or sneezing, onset of headache after age 50, headache associated with change in neurological status and headache with abnormal examination findings.[23]

Almost everyone with migraine needs no investigation. The goal of investigating is to exclude other causes of migraine-like symptoms, not to confirm migraine—which tests can never do.[52]

METHODS:

Electroencephalogram

Computed tomography (CT) and magnetic resonance imaging

Cerebral Angiography

Magnetic resonance angiography

Lumbar puncture [34]

Indicators for ordering EEG

Alteration or loss of consciousness

Transient neurological symptoms without ensuing headache

Suspected encephalopathy

Residual persisting neurological defects.

Indications for Neuroimaging

1. The first or worst headache of the patients life, particularly if it is of rapid onset (thunderclap headache)
2. A change in the frequency, severity or clinical features of the headache attack.
3. An abnormal neurological examination
4. A progressive or new daily persistent headache
5. Neurological symptoms that do not meet the criteria of migraine with typical aura or that themselves warrant investigation.
6. Definite EEG evidence of a focal cerebral lesion
7. Perhaps hemicrania that is always on the same side and associated with contra lateral neurological symptoms.
8. If routine therapy has not led to the anticipated improvement.[34]

Indications for lumbar puncture

The first or worst headache of his life

A severe, rapid-onset, recurrent headache

A progressive headache

An atypical chronic intractable headache.[34]

Other tests:

A complete blood count and differential may rule out anaemia or infection. The antinuclear antibody test screens for autoimmune conditions. A sedimentation rate not only acts as a screen for serious conditions such as malignancy or collagen vascular disease but it can also establish the diagnosis of temporal arteritis a cause of headache in the elderly.

Thyroid function tests are performed to rule out thyroid disease states such as thyrotoxicosis, a condition that may exacerbate headache. Unexpected or overused medication that has a direct impact on headache and its treatment can be identified by a drug screen and toxicology studies.[34]

MANAGEMENT

General measures include

Reassurance and relief of anxiety

Avoidance of dietary factors [21]

TREATMENT

Effective migraine treatment begins with making an accurate diagnosis, explaining it to the patient, and developing a treatment plan that considers the patient's diagnosis, symptoms and any coincidental or comorbid conditions.

Conditions that occur in migrainers with a higher prevalence than would be expected include stroke, epilepsy, mitral valve prolapse, Raynauds syndrome and psychological disorders which include depression, mania, anxiety and panic.

Table. No: 5 Migraine comorbid diseases

Migraine comorbid disease. [34]				
Cardiovascular	Neurological	Gastrointestinal	Psychiatric	other

Hyper-or hypotension Raynauds phenomenon Mitral valve prolapse Angina/myocardial infarction Stroke	Epilepsy Positional vertigo	Functional bowel disorders	Depression Mania Panic disorders Anxiety disorder	Asthma Allergies

Relaxation, biofeedback and behavioral interventions, such as marinating a regular schedule, getting adequate sleep and exercise, and giving up tobacco, are helpful in some patents. Biofeed back is a useful treatment that serves to engage patients in cognitive behavioral therapy. It is especially useful in children, pregnant women, and patients in whom stress is the trigger.[34]

Table. No: 6; Behavioral Modifications in migraine management

BEHAVIORAL MODIFICATIONS [34]	
May help	Less likely to help
Regulate sleep Regulate exercise Regular meals, Avoid chocolate Avoid tyramine-containing food Avoid monosodium glutamate Avoid alcoholic beverages Limit caffeine Limit medications Biofeedback or stress management.	Avoid milk products Avoid citrus products.

Prevention of Migraine

More than a century ago, Sir William Osler recognized the importance of migraine precipitation by triggers and advocated that its treatment "should be directed toward the removal of the conditions upon which the attacks depend..". By having patients record the time, date, and circumstances pertaining to each of their migraine headaches, they acquire knowledge of how these may be prevented. While it is true that triggers may be variable, even in individual patients, and that some are unavoidable, Blau found that 50% of patients with intractable migraine could reduce the frequency of their attacks by 50% by eliminating various triggers.[44]

Because stress often triggers migraines, who are habitual sufferers should learn relaxation and stress management techniques. These are especially helpful in aborting

headaches when warning signs are felt. Massage, relaxation exercises of the neck, shoulder, and jaw muscles may all be helpful. Rest in a dark room with cool compresses can prevent the headache. Foods such as alcohol, aged cheeses, chocolate, fermented or marinated foods, MSG, artificial sweeteners such as aspartame, and caffeine all may trigger headaches; diet should be monitored to reduce or eliminate intake of these. Nicotine may cause migraine - yet another good reason to give up smoking! [59]

HOMOEOPATHIC CONCEPT AND APPROACH

The law of Similars is the fundamental law in which the system of homoeopathy rests

The law of Similars in its application demands exacting standards of precision, since an exactly similar drug alone can prove curative. This exact similarity can be ensured only if the patient is observed closely as an individual instance of the disease, making a special note of characteristic features that will positively separate it from another instance of the same disease. This is achieved through the principle of individualization

The homoeopathic physician considers disease as a deviation from the health, which is made known to him only through signs & symptoms. It logically follows from this that a rational system of therapeutics will have these very signs and symptoms pointing unmistakably to a curative remedy agent

When we study an individual we not only study the bodily configuration but also the intellectual and emotional attributes as revealed to us through his reaction to the environment. Thus the characteristics in the physical as well as in the intellectual and emotional spheres reveal the individual to us.

We are all aware that no two individuals are alike, except uniovular twins, from this it logically follows that their reaction even to identical disease-producing factors will necessarily differ in certain details although retaining some common features which enable the nosological classification of diseases. It is these, which enable the homoeopathic physician to separate one instance of the disease from another.

A homoeopathic physician requires sufficient tact & mastery of the technique of case taking in order to obtain all this detailed information about the individual. He evaluates each symptom according to its importance from the standpoint of totality. He then synthesizes them

according to definite pre-conceived plan which enables him to bring scattered elements together to evolve a characteristic form or outline. At this stage he is interested only in the general salient features that give him a bold outline picture of the patient which corresponds to a few drug-pictures from the homoeopathic Materia Medica. Once this is achieved, he looks around for certain details to confer greater individuality on the image. This process is continued till the image unmistakably points to a single drug picture. This, then, is the special technique of repertorization founded by Boenninghausen and developed later by Kent and Boger.

A mastery of this special technique of case taking and repertorization is essential for successful application of the concept of individualization, which is the very basis of homoeopathic practice [11]

MIGRAINE

Migraine, also called hemicrania, is a disease characterized by paroxysms of headache, generally associated with vasomotor and sensory symptoms. Bartlett calls it a disease of civilization and says that no neurosis numbers among its victims, so many eminent scholars. It occurs more frequently in persons of neurotic constitution and about two-thirds of the sufferers are women. Heredity has a strong influence in its production.

The attacks are usually preceded or ushered in by some sensory symptoms: a feeling of great fatigue, a heavy head, or something related to the special senses, most often to that of sight. These visual disturbances vary with the individual case, sometimes taking the form of one-sided dimness of vision, even progressing to temporary blindness; or again there is an appearance of fiery lines, making different forms, or saw-teeth of fire in rapid motion.

The headache itself usually begins in a small spot or on one side and increases in force and extent until it affects all one side of head or even the whole head. In many cases it extends to the neck, shoulders and even arms. The pain itself is usually extreme, sharp, throbbing or boring, much worse for light, sounds, jar, or any decided motion. Rest in bed is absolutely necessary.

The pain often causes nausea and vomiting, which may take place repeatedly until bile is vomited. Many times the pain is relieved by vomiting and the patient falls asleep to wake feeling better. While the above symptoms represent the ordinary case of migraine, each case is apt to show individual variations.[36]

Dr. Hahnemann has classified migraine under the psoric miasm (Aphorism – 80, Organon of medicine) [15]

Migraine and its management in homoeopathic literature,

J.Ellis Barker

A considerable number of migraine cases have come my way, and I have been fortunate in the great majority. A vegetarian diet will frequently produce great relief and occasionally a cure in some cases. Migraine is due to coffee which may agree well with the victim who has not the slightest suspicion that it produces these temporary prostrating attacks. In his paper on the effects of coffee, published by Hahnemann in 1803, we read: " if the quantity of coffee taken by immoderately great and the body very excitable and quiet unused to coffee, there occurs a semi-lateral headache from the upper part of the parietal bone to the base of the brain. Very slight things cause in the coffee-drinking lady migraine, or a frequent often intolerable toothache on one side of the face. The migraine alluded to only appear after some exciting cause, such as vexation, over loading of the stomach, chill etc. and differs entirely from the so called nervous hemicrania. The pain is almost intolerable; in very bad cases I have seen it last 36 hours"

There is not a single cause for migraine and neuralgic headaches, not every case can be cured by non flesh diet and abstinence from coffee. The benumbing drugs employed by the orthodox medicine have not cured a single case, while the homoeopathic medicines indicated not by the name of the disease but by the individual headache symptoms of the sufferer have cured numerous cases.[2]

G.H.G.Jahr, states, This is a true neurosis like epilepsy, eclampsia and other spasmodic attacks, not proceeding from the stomach like gastric headache, but irritating the stomach after the megrim has reached its height, moreover the course of single paroxysms, independently of differences in their duration, from 24 to 36 hours, is in all cases the same in so far as every attack sets in quite suddenly, after which there is regular increase, vomiting is frequently excited at the point of culmination, after which the attack decreases again with equal regularity and finally disappears with out leaving a trace behind until next paroxysm.

It is remarkable that belladonna, nux vom, calc even Ignatia, the last named especially in the case of hysteria females, like wise sulph and silic and other epileptic remedies have in my practice, afforded more permanent relief in this headache.[17]

John H Clarke about Sick Headache or Migraine. - This is not due to disorder of stomach but is a constitutional disorder, nausea or vomiting being one of the symptoms depending on disturbances of the nerves and brain.[9]

Richard Hughes states Megrim is a neurosis like epilepsy, having its periods of incubation and its paroxysms- the latter should be treated with drugs corresponding to their features- belladonna, Ignatia, nux vomica, digitalis, cyclamen, niccolum, iris and sangunaria. Sometimes one or other of these will control the morbid tendency; but more frequently we have to deal with by means of deeper acting medicines such as calcarea, sepia, silicea, stannum and zincum which deal with the general disorder of which the paroxysm are but an expression. By the use of both of these classes of remedies in their respective place we are best likely to control the disease.

Hemicrania is a disease, which requires to be closely individualized. When you have selected what seems the simillimum, administer it in frequent doses, during the paroxysm, in rare ones through the interval, and give it a through trial before you change it.[16]

C.G.Raue quotes, Hemicrania or migraena or nervous sick headache is a peculiar form of half sided headache, which by some, has been considered as a neuralgia of the temporal, frontal and occipital nerves, or as a hyperaesthesia of the brain, or a cerebral neuralgia, or as a hysterical manifestation of some derangement of the menstrual function.

Migraena is most frequently met with in women of a hysteric, chlorotic or anaemic tendency, and a weak and nervous constitution, also in married women who have no children, and in young widows. Men of weak constitution, who read and study much in the night, or who lead a loose life, are likewise subject to migraena. In all, it seems that the habitual use of coffee and tea has a great deal to do with its periodical recurrence [30]

Tom whitmarsh mentions, It is now clear that migraine, far from being a psychological disorder of nervous people (a common perception), is a definite neurological disorder to be taken very seriously.

Treatment of migraine is usually thought of in terms of measures to treat the symptoms of an attack (acute treatment) and measures to cut down the likelihood of attacks starting at all. Homoeopathy offers the possibility of acute treatment but, more importantly, the chance of cutting the number of attacks and sometimes abolishing them altogether, without unacceptable side effects.[42]

When managing migraine you have symptomatic treatment as it happens and treatment that cuts down the likelihood of the attack occurring in the first place, sufferers often use both strategies. Homoeopathy generally falls into the latter category. Belladona or Bryonia are sometimes effective as acute treatments, but my best successes usually come with deep acting

constitutional therapy based on the individual characteristics of migraine and also taking account of other specific aspects of physiology and personality.[43]

Mount S.J.L. states Migraine is a dynamic happening and intimately related to patient's psychology, constitution, social Environment and place in life. The form that migraine takes relies to a large extent on the physique and make up of the individual. This is perhaps where homoeopathy comes into its own, where the homoeopathic constitution plays a part. Many remedies can benefit the same patient at different times both during his attacks and during his whole life experience of migraines.[24]

Rajesh Shah quotes, Many independent studies at various institutes have also shown that most migraine sufferers show one or many of the following behavioral pattern: conscientiousness, fastidiousness, rigidity of views, constant
Conflict between the environments and self, high level of expectation.

The homoeopathic approach to the treatment of migraine patients is more individualistic. This means, homoeopathy believes that migraine is a personality disorder and hence the treatment should be determined only on the basis of in-depth study of the patient's personality. This approach helps treating most cases of migraine successfully.[51]

REPERTORY

Repertory is an index to the homoeopathic Materia Medica, which is full of information collected from toxicology, drug proving and clinical experience. The repertory helps us to find out the required symptoms, together with the medicine or a group of medicines having different grades. It is a connecting link between the Materia Medica and disease.

The process of repertorization is essentially a logical elimination of apparently similar medicines. It starts with a broad choice and gradually narrows down the field, which provides us an adequate and a small group of similar medicines, so that the final selection of the simillimum is easier with the help of further reference to the Materia medica.[37]

Need for repertory

The homoeopathic Materia Medica, which records multitudinous symptoms of drugs, is like an ocean. Certainly, one cannot afford to refer all similar drugs in the Materia Medica corresponding to the disease picture. It would be time consuming and at the same time confusing. Therefore, a need was felt for a working manual to ease the task of finding out a specific drug. Such a need was felt as early as in the Hahnemann's era. [37]

Dr. Hahnemann who proved several drugs could not prescribe medicines to his patients without consulting and comparing provings of several drugs. The process was laborious and was consuming lot of his time and talent. Then, he felt the need for some sort of indexing of symptoms and it was to solve the hurdle he thought, " For convenience of treatment, we require merely to jot down after each symptom all the medicines which can produce such a symptom with tolerable accuracy, expressing them by a few letters (Eg. Ferr, Chin, Rheum, Puls) and also to bear in mind the circumstances under which they occur, that have a determining influence on our choice, and proceed in the same way with all the other symptoms, noting by what medicine each is excited; from the list so prepared we shall be able to perceive which among the medicines homeopathically covers the most of the symptoms present, especially the most peculiar and characteristic ones, and this the remedy sought for "(Materia Medica pura, Preamble – originally published in 1816) This laid the foundation of the present day repertories.[26]

Thus, a new subject was pursued. In fact, most of the stalwarts had felt the need of a repertory and found it difficult to practice with out it, the repertory is an out come of the logical human mind.[37]

Dr.Boenninghausen expresses the need for a repertory in preface to his Therapeutic pocket book as " there is no doubt that a diligent and comprehensive study of the pure materia medica cannot be accomplished by the use of any repertory whatever. I have not indented to dispense with such a study, but rather have considered all works of such intent positively injurious. Still, it is not to be denied that a homoeopathic physician can only devote himself to such studies in his leisure hours (Which are, indeed, few enough), and that he needs in his practice, to aid his memory, a work which is abridged, easily consulted, and which contains the characteristic symptoms and their combinations, to enable him, in any individual case of sickness, to select from the remedies generally indicated the one suitable and homoeopathic, with out a too great loss of time" he also states that " it is by far more difficult for the inexperienced homoeopathist to cure patients even with a few symptoms with out a repertory, because many remedies seem to correspond"[1]

J.T. Kent states that, "The use of repertory in homoeopathic practice is a necessity if one is to do careful work. Our Materia Medica is so cumbersome with out a repertory that the best prescriber must meet with only indifferent results.[19]

The proper use of the repertory will lead to correct off hand prescribing in simple cases, in from ten to twenty years. The mechanical use of repertory never leads to artistic prescribing nor to remarkable results."[18]

Burnett comments, "In ultimate court of appeal there remains the priceless repertory to lead us to correct choice of the remedy. With me, personally, the repertory has always been my reserve force, to be called out only in case of need, but, for all that, I feel and know full well that, with my repertory. In reserve, I am never quite beaten"[7]

Garth Boericke states as follows "The use of the repertory is certainly an art in the highest sense, calling for nice judgment and sound evaluation of symptoms" [4] and J.H.Clarke:- "The use of repertories is in itself an art which the homoeopathist must diligently cultivate."[10]

Frederik Schroyens tells the importance of repertory as "Repertories have helped conscientious homoeopaths in their struggle for the right remedy as long as homoeopathy has existed."[31]

"The repertory becomes a place were people exchange their experiences. The repertory becomes a center of communication, a meeting room where hypotheses are formulated, and where first impressions are verified." [31]

S.K.Tiwari in his book Essentials of repertorization mentions as "A remarkable progress has taken place in the field of repertory, especially during the last few decades. Rapid advancement in the field of repertory would surely and largely contribute in making the homoeopathic system the first line of treatment."[37]

A.H. Grimmer states as "The very existence of homoeopathy in the future depends upon the through training of her followers in knowledge of the philosophy together with an intelligent use of repertory."[26]

"These days, when more than 4,200 medicines are known to the profession and each medicine has a vast symptomatology, the repertory becomes an essential tool in finding out an indicated medicine"[37]

Repertory uses

1. To find out the simillimum.
2. As a reference book
3. It helps the study of Materia Medica
4. Helps to find out a complete symptom.

5. It helps in formulating questions, which is an essential ingredient of case taking.

6. Its constant use makes a physician efficient. By constant handling, one refreshes Knowledge of the Materia Medica, different symptoms and medicines with different grades.

7. It suggests related remedies, which could be helpful for selecting a drug for a Prescription. Boenninghausen has written a separate valuable section on the relationship of remedies.

8. The quest for compiling an updated repertory has not only given birth to many repertories, but also to authentic repertories. Modern repertories can also be considered as source of information. Each medicine mentioned against the rubric also carries the source of information. This unique advantage can be had from repertories.

9. Through the references and 'cross- references' one can know the similar rubrics. Thus repertories help to us to select the right rubric among similar rubrics.

10. Addition of a number of medicines, clinical rubrics and pathological generals helps in the study of homoeopathy in relation to the modern pathology.

11. With the introduction of the computer repertory, it has become an invaluable companion, both for Clinicians and academicians. It helps in a speedy retrieval of the known facts [37]

Steps to repertorization.

Repertorization is not only a mechanical process of counting rubrics and totaling marks obtained by a medicine, it also includes the logical steps to reach the proper remedy and finally differentiating the remedies with the help of the Materia Medica. Repertory follows the logic of induction and deduction. The steps to repertorization start from case taking and end by finding out the simillimum. They are:

1. Case taking
2. Recording and interpretation
3. Defining the problem
4. Classification and evaluation of symptoms.
5. Erecting totality
6. Selection of a proper repertory.
7. Repertorial result

8. Analysis and reportorial result and prescription [37]

Any remedy correctly worked out when looked up in the Materia Medica should be perceived to agree with, and to fit the patient, his symptoms; his parts and his modalities. It is quite possible for a remedy not having the highest marking in the anamnesis to be the most similar in image, as seen in Materia medica.[18]

The value of any repertory depends upon several elements:

1. The art of the physician in taking the case.
2. A knowledge of the repertory one attempts to use.
   (a) Its philosophic background
   (b) Its construction
   (c) Its limitations
   (d) Its adaptability
3. Intelligent use of the resulting analysis.[1]

One must be thoroughly conversant with the underlying principles that have guided the compiler of the repertory one is using and the plan on which it has been organized. This facilitates quick spotting of rubrics and most economical and fruitful way of combining them, if one is not acquainted with the organization of the material in the repertory, it remains a closed book.[11]

George Vithoulkas states, it must be always remembered that repertorization is merely a clue, a hint. In the last analysis, the results of repertorization must be forgotten while the homeopath's full attention is placed upon the study of Materia medicas.[40]

SYNTHESIS. (REPERTORIUM HOMOEOPATHICUM SYNTHETICUM)

Synthesis is the enlarged Repertory of Kent, linked to the homeopathic software program Radar. Radar was created in the early Eighties and *Synthesis* has been at the core of its development since the very beginning. Each new version has been the fruit of thousands of hours of work by many dedicated people. Synthesis was enlarged with additions, but they only increased 15 to 30% at each step. Every version of Synthesis has been used millions of times by leading homeopaths during their daily work before it was used to build another edition.[32]

Synthesis is a work in progress, continuously being updated, verified, and redefined. *Synthesis* represents the fusion of the past with the present. It combines the tried and true historical findings of homeopathy with today's influx of new findings by the Homeopaths of today (and tomorrow). Synthesis is unique in that a key fundamental philosophy is to never sacrifice quality for quantity. [49]

Synthesis is the repertory of choice in homeopathic schools around the world. Synthesis is used in more than 60 countries and is available in German, French, Italian, Portuguese, Dutch, and Spanish. Synthesis is available both in a book version and as electronic media (RADAR). [49]

THE REASON FOR SYNTHESIS

Repertories have helped conscientious homeopaths in their search for the correct remedy as long as homeopathy has existed. Samuel Hahnemann, the founder of Homeopathy, took the first steps in structuring information into some kind of repertory. However, it was his immediate disciple and collaborator, Clemens Von Boenninghausen, who is credited with creating the first usable repertory in 1832. Different authors expanded on versions of this repertory, e.g. Allen, Jahr, Von Lippe, etc. Some created completely new structures, as did Gentry and Knerr. It was Kent, however, who published a repertory with a structure and a hierarchical logic that would stand the test of time.

As good as Kent's Repertory is, it is not complete or perfect. This is the nature of any repertory. The repertory must evolve through clinical experience, provings, diligent practice, with cautious improvements and additions.

For decades, no repertory succeeded in taking up this challenge of careful progress. In 1987, however, the Synthesis project began. Under the supervision of Dr. Frederik Schroyens, this collaboration of homeopaths from around the world has succeeded in significantly expanding and improving upon Kent's great Repertory, without a compromise in quality. Combined with the powerful homeopathic software program known as RADAR, it has equipped today's practitioners with the powerful database tools necessary for finding the correct remedy for their patients.

Synthesis is not only the latest in a long line of Repertories; it consolidates one of the most ingenious homeopathic projects of this century. Each new version has been the fruit of thousands of hours of work by many dedicated people. Synthesis repertory is enlarged with additions, but they only increased 15 to 30% at each step. Every version of Synthesis is used millions of times by leading homeopaths before it is used to build another edition. As can be expected from these critical minds, they have checked the rubrics and the remedies repeatedly. Their comments are integrated into each new edition.

The Synthesis project was started because the time had come to improve, on a qualitative level, the language and structure Kent used, but within the hierarchical framework that most homeopaths are familiar with. This approach will prove the best way to counteract the mentality where progress in homeopathy is measured by quantity, be it additions or megabytes

available. Synthesis is a sound reportorial database from which to make additions. The objective was to do it without compromising the accuracy of the information and the efficacy of the results.[49]

History of Synthesis

Radar was first developed as a research project at the University of Namur (Belgium) under the supervision of Jean fichefet, Professor of mathematics at the University of Namur, Belgium, department of computer science. His sympathetic reaction after the homoeopathic cure of his son was the beginning.

In the beginning there was just a small group of Belgian Homoeopaths gathered around Professor Jean fichefet. As the interest in the program rose so quickly, it became necessary to entrust the organization and international representation to professional and dedicated people.

It is based on the Sixth American Edition of Kent's Repertory, and contains all its rubrics and remedies. Since ***1987***, Synthesis has been used as a database for the Radar program in the daily practice of leading homeopaths. It has been commented upon and thereby improved over and over again, which gives it an outstanding label of quality. Not only additions of an increasing number of authors have been added to all chapters, but also corrections of the existing data, including of Kent's work, have been integrated.

Version 2 was released in ***April 1988*** and occupied 10.5 MB of a hard disk space.

Synthesis 3 followed in ***September 1990*** with 11.5 MB: it contained mostly corrections on the previous version and offered 136,000 additions from about 130 authors compared to Kent's original Repertory.

In ***December 1992*** the ***fourth version of Synthesis*** was released. It contains 178,000 additions from about 200 authors. Many additions are confirmed by different authors and thereby become more reliable.[32]

Synthesis 5th version was first time available in book form in ***1993***.[37]

The printed editions of synthesis correspond to the fifth version of the computer database.[31]

Version 4 of Synthesis contains about 178,000 additions to Kent's Repertory. This number has "only" increased by a few thousand additions for version 5.[32]

Synthesis 6th version was published in ***1995.***

Synthesis 6 was released as a computer version and printed in German. It contained almost exclusive changes in the chapter mind.[32]

Synthesis seventh version was published in ***1997.*** The seventh version is enriched with many additions and more than 2000 medicines.

Repertorium Homoeopathicum Syntheticum **8.1** is also ready for the profession to be used. [37]

Plan and construction

Synthesis repertory follows the plan & construction, arrangement of rubrics as of Kent's repertory. It is based on Kent's philosophy of general to particular. The method of repertorization follows Kent's method of repertorization.

Any case rich in generals and characteristic particular can be repertorized by *synthesis*. A case having only characteristic particular too can be repertorized by using this repertory. Almost all type of cases can be repertorized by using *synthesis.*[37]

Table. No: 7; Gradation of remedies in Synthesis

Gradation	Printed	Software version
1st grade	BOLD CAPITALS	BOLD CAPITALS WITH UNDERLINE
2nd grade	Bold	BOLD CAPITAL
3rd grade	Italics	*Italics*
4th grade	Roman	Roman

Table No.8; Chapters in synthesis Repertory

CHAPTERS 38	
1. Mind	20. Prostate gland
2. Vertigo	21. Urethra
3. Head	22. Urine
4. Eyes	23. Male Genitalia/sex
5. Vision	24. Female Genitalia/sex
6. Ear	25. Larynx And Trachea
7. Hearing	26. Respiration
8. Nose	27. Cough
9. Face	28. Expectoration
10. Mouth	29. Chest
11. Teeth	30. Back
12. Throat	31. Extremities
13. External Throat	32. Sleep
14. Stomach	33. Dreams
15. Abdomen	34. Chill
16. Rectum	35. Fever
17. Stool	36. Perspiration
18. Bladder	37. Skin
19. Kidneys	38. Generals

The hierarchical structure of the repertory :

The hierarchical structure of the Kent's repertory has been maintained because Kent's Repertory has maintained its position of reference throughout this century. It allows immediate

comparisons of related rubrics. If "left" is positioned just below "right" their remedies are compared at a glance.

1. GROUPS OF SYMPTOMS

Symptoms are divided in groups and these groups are always following each other in this same order:

SIDES

TIMES

MODALITIES

EXTENSIONS

LOCALIZATIONS

(DESRIPTIONS OF PAIN / Other descriptions)

Example: symptoms present in the various groups of "Head - Pain":

Sides: right; left; ...

Times: morning; noon; ...

Modalities: air; coughing; eating; ...

Extensions: ear; teeth; ...

Localizations: brain; forehead; ...

Descriptions of pain: biting; boring; burning; ... This order of groups is repeated at each level if needed. You can expect a hierarchical structure like this at several levels.

2. "SIDES"

The block "sides" consists of these symptoms (in this order!) with any subrubrics they may have:

- One side.
- Alternating sides.
- Right.
- Left.

3. "TIMES"

All time schedules are reformatted following the same standards. The "a. m. - p. m." was replaced by the international timetable "0 - 24 h".

4. "MODALITIES"

4a: General remarks

AGG. is usually not mentioned! Check if the meaning of the rubric is clear if you read the modality the reverse way adding "... causes or aggravates x". E.g.: "Head - pain - lying": read: "lying causes or aggravates: head - pain". If it is there is less (no) need to mention "agg."

.AMEL. is always the last level of a symptom. Otherwise ambiguity arises concerning the subrubrics that depend on it.

In the majority of the cases "xxx - AILMENTS from" indicates the same as "xxx - agg.". To avoid repetition, only the latter rubric has been maintained in these cases (E.g.: Generals - food - wine - agg = generals - food - wine - ailments, from).

PREPOSITIONS are often not mentioned when they do not add to the meaning of the symptom. This applies especially to prepositions such as "when, during, from, on, while, ..." where the preposition in fact only means "aggravates or causes".

E.g.: rising, on => rising

lying, while => lying

Modalities are sorted ALPHABETICALLY, except: for a level 4 or more, if the modality expresses time, then the order should be "... - before"; "... - during" and "... - after". Other modalities depending on the same 3-level symptom, will then follow after these.

4b: "Alternations".

Write "alternating with - <next level>".

The alternations are a modality, and are sorted alphabetically in between the modalities, e.g. after "air". Synonymous rubrics are to be avoided here as well: a synonym refers to the other symptom, which only contains the remedies. Alternation between eruption and asthma will be found under CHEST - Respiration - asthmatic and not under SKIN - eruptions as asthma is the more vital complaint.

4c: Periodically recurrent events are often difficult to find:

All periodically recurrent events are made as subrubrics of the Rubric "periodical"

"skin -discoloration - bluish – periodical - annually"

The level "periodical" is positioned on the highest level, according to the logic of the repertory.

The period of time after which a symptom recurs is indicated as a multiple of hours, days, weeks or months. If a number of days coincides with a (smaller) number of weeks, the number of weeks is used in preference.

E.g.: three days

ten days

two weeks instead of fourteen days

twenty-five days

"recurrent" is most often not a subrubric of "periodical" as it does not imply any regularity or periodicity in its re-occurrence. If an event is recurrent, but not periodically recurrent, the rubric remains "recurrent"

E.g.: Eye - styes - recurrent"

4d: Illogical superrubrics

Kent's Repertory is filled with "illogical superrubrics", often caused by the simplicity of the lay-out. This means that a certain superrubric does not make sense for the subrubrics that depend on it. In *Synthesis* such illogical superrubrics have been modified so that you can clearly read all levels of any subrubric after another and they still make sense.

E.g.: "extremities - drawing up limbs agg. - amel." is modified into "... - drawing up limbs - amel."; "urine - color - yellow, light - dark" into "... - yellow - dark";

4e: Modalities grouped under a global superrubric:

Some modalities are not present one by one, but as subrubrics under a common heading. In this way the symptoms can be found more easily at one place.

Children

Babies > children - babies

Nursing infants > children - nursing infants

Schoolgirls > children - schoolgirls

4f: Food and Drinks (agg, amel, aversion and desire)

All other food modalities are subrubrics of the four leading food -modalities: agg., amel., aversion and desire.

"ailments": Note that: "wine -ailments, after" is considered to be the same as "wine - agg". Only the latter is maintained.

In STOMACH: you will find desire and aversion without additions compared to Kent's Repertory. All additions to the above rubrics are in "GENERALS - Food"

4g: Combined modalities.

Thousands of modalities refer to two or more modalities at the same time: cold air, warmth of bed, open air, draft of air, warm drinks, cold bathing, warm applications amel, etc. About half of them are written with the "temperature - component" as leading word (= cold bathing amel), and half of them with the other component as leading word (= bathing - cold

amel). (E.g.: extremities - pain - upper limbs - washing - cold water, but: extremities - pain - tearing - fingers - cold washing).

Another example: "cold wet weather" refers to 14 symptoms in the original Kent. "Cold damp weather" to 28. So far, additions have been made in both ways. In both cases, some symptoms are not to be found under c(old) or d(amp) but under w for weather!

To solve this confusion, we have elaborated a format for "combined modalities" to which we transcribe all new symptoms.

4h: Synonymous rubrics.

As a rule synonymous rubrics are merged into only one rubric, which is the only one to contain the remedies. All other rubrics refer to the latter. The rubric with the remedies and with the subrubrics is the one in the more vital chapter.

E.g.: "mind - excitement - alternating with - convulsions" is the same as "generals - convulsions - alternating with - excitement". There will be a synonym in the chapter "generals" and the remedies will be found in "mind", the more vital chapter.

5. "EXTENSIONS" (in pain sections).

The format of these symptoms always begins as follows:

.... - extending to - <whatever region>,

also if the region is not linguistically linked to "extending to" (e.g.: upwards).

There are in fact three types of information that can follow "extending ...":

extending (upwards, ...)

extending to (back, ...)

6. "LOCALIZATIONS".

- The first letter of a localization is upper case - Forehead
- If the localization is composed, only the first letter is a upper case - Upper limb
- If the localization has sub-Localizations, these are lower case - Fingers - first

7. "DESCRIPTIONS OF PAIN"

A description of pain occurs only at level 3 of a symptom (head - pain - stitching").

If another description of pain is added to explain (modify) the main one, the latter is sorted between the modalities (not again as another description of pain-level). E.g.: "Eye - pain - stitching - burning": burning is sorted among the modalities of stitching.

8. "OTHER DESCRIPTIONS".

In a limited number of rubrics, the modalities (or extensions, whichever group of symptoms happens to be the last) are followed by a second alphabetically ordered group of symptoms. These are not descriptions of pain, but rather descriptions of the characteristics of the symptom.

In these symptoms, the alphabet will start a second time to describe these "other descriptions".

This is the case for the following 2-level symptoms:

- Head - noises
- Vision - colors

SYNONYMS AND CROSS-REFERENCES

The difference we are making between these two categories of words is based on a technical difference in the repertories in making references from one rubric to another:

CROSS-REFERENCES are rubrics with remedies referring to other rubrics with remedies. The meaning is similar, but sufficiently different to legitimate a different rubric. Remedies and subrubrics are added to the most appropriate rubric.

SYNONYMS are rubrics without remedies referring to a rubric (Master Synonym), which contains remedies. In repertorial language, the synonym rubrics are considered synonymous with the master synonym. The remedies and subrubrics are added under the master synonym.

Reasons for the exceptional quality of this Repertory are:

Synthesis is a great contribution to the homoeopathic profession because of its special features mentioned below:

Synthesis contains repeatedly checked additions from the standard homeopathic literature, including Kent, Hahnemann, Hering, Allen, Clarke, Boericke, Knerr, etc. Additions from living authors are added only with caution and most often only in the first degree unless confirmation (of a higher degree) comes from other authors.

Thousands of corrections to Kent's Repertory have been made. They are recognisable as the remedy in these cases mentions "K" (= Kent's Repertory) as well as the reference indicating the source of the correction. E.g.: "Delusion - starve - he must": kali-m.k,c1 indicates this remedy in Kent was corrected on the basis of a symptom in Clarke's Dictionary. More rarely this type of reference is used to indicate a confirmation of Kent's information.

Thousands of symptoms have been rewritten following a clearly readable "symptom format". At each level, either the words follow each other in the normal order, or the sentence is split only once. This split is indicated by the sign ";" to show the place from which one should

start reading. This differs from the presence of a "," which is used to improve readability. E.g.: "pieces, sensation as if head would fall in, when stooping" became: "pieces, on stooping; sensation as if head would fall in"

The structure of the symptoms has been made more transparent in order to avoid all possible ambiguity. This was especially the case for symptoms where sub rubrics seemed to depend on super rubrics with a contradictory meaning. E.g.: "generals - trembling externally - internally - joy, from" became "generals - trembling - externally - joy, from"

A list of combined modalities has consistently been applied throughout Synthesis: the parts of a same combined modality can always be found in the same order. E.g.: "cold wet weather" is to be searched as "weather - cold - wet", never under "cold damp weather" and never under "damp cold weather"

Leading words have been positioned in front at each level and the alphabetical sorting was corrected accordingly if necessary. E.g.: "in bed" => "bed, in"; "as if frozen" => "frozen, as if", ...

Insufficiently clear symptoms have been completed on the basis of the Materia Medica. E.g.: "cough - Sulphur fumes or vapor, sensation of agg." => "cough - Sulphur fumes or vapor; cough agg. by sensation of"

Whenever possible ambiguous words have been clarified. E.g.: "breast" has been replaced by "chest" or "mammae", "storm" by "stormy weather" or by "thunderstorm", ...

Some global superrubrics were created so that one can find more easily related symptoms. E.g.: symptoms on "periodicity" or "children" have become subrubrics of "periodicity" and "children" respectively. Too similar rubrics were merged into one. E.g.: "nose - obstruction - alternating sides" and "nose - obstruction - one side - alternately"

Symptoms were split into meaningful bits whenever this was not yet done by Kent. E.g.: "cough - loose - exercise and warm room agg." was split in two rubrics "exercise" and "warm room - going into a warm room" (for the correction: see Bromium in HR1)

The language of the Repertory has been completely revised. Nineteenth century spelling has been consistently replaced by modern American English spelling. The whole book has been spell-checked by computer. E.g.: "anaemia" became "anemia";"diarrhoea": "diarrhea"; "faeces": "feces"; "haemorrhoids": "hemorrhoids"; ...

For hundreds of words or expressions, written in two or more ways, only one has been maintained, based on Webster's Dictionary. E.g.: "descending stairs" in Synthesis replaces "descending stairs, when", "descending steps", "going down stairs" and "stairs, on going down",

all of which exist in Kent. Seldom used words and expressions have been replaced by contemporary language, for everyday language as well as for medical expressions. E.g.: "dipsomania" by "alcoholism", "childbed" by "delivery - after", ...

Clinical rubrics were renamed according to modern disease names. New clinical rubrics were introduced with caution, as sufficient clinical verification is still lacking in most cases. E.g.: "coryza - annual" became "hayfever"; "skin - becomes sore" became "decubitus", ...

A new standard list of remedy abbreviations is presented. Many new remedies have been added, all abbreviated following the same rules used by Kent. The differences between the remedy abbreviations of Synthesis and those used so far in Kent or in Barthel's Synthetic Repertory, are printed at the beginning of this book. The full list and all comments follow at the end.

A new standard list of author abbreviations is presented as well. Letters are used to indicate an author. This allows more combinations and is easier to memorize .[32]

THE SOURCES

Synthesis encompasses the additions from the Repertories that are primarily used today: Boger's version of Boenninghausen's Repertory, Boericke's Repertory, Phatak's Repertory, etc. Information from different Materia Medica has been integrated, especially from classical authors such as:

- Hahnemann - surprisingly, many of Hahnemann's symptoms seem not to have been integrated into Kent's Repertory.
- Kent's Materia Medica - fully integrated on the basis of Dr. Linda Johnston's tremendous work. (USA)
- Hering's Encyclopedia - this source was preferred over copying from the secondary source, Knerr's Repertory, which contains the same material.
- Allen's Encyclopedia - the original book, not the index (which contains many mistakes and omissions).
- Roberts' "Sensations as if" - Although some consider it to be a Repertory, it is a full text structured line by line. It has taken much time to transcribe it to a correct repertory structure. The entire book has been integrated into Kent's Repertory.
- Many other Materia Medicas were integrated. Worth mentioning are: Clarke's Dictionary, William Boericke's Materia Medica, Phatak's Materia Medica,

Borland's books, Tyler's Drug Pictures, the works of Dunham, Farrington, Lippe, etc.

Synthesis includes the additions from Henry Allen's Nosodes, reviews of carcinosinum, psorinum, different strains of tuberculinum and medorrhinum. An important number of clinical observations from various "living" authorities were added. Overall, Synthesis contains the most complete representation of nosodes to be found.

George Vithoulkas has gathered a great number of homeopaths in a Clinical Center in Athens, and estimates having reviewed more than 150,000 cases. From this extensive pool of clinical experience, Vithoulkas has personally collected more than 1,600 controlled additions for the 'Mind' chapter, and these are integrated into Synthesis. On Vithoulkas' instructions, additions to other chapters have been added in successive versions of Synthesis. We have also included his indications on changes of degree (most often a higher degree).

Future additions to Synthesis, as well as those that have come before, will be the result of the collaborative efforts of thousands of homeopaths worldwide. It is only this intense combined focus and attention that allows the creation of such a precise and accurate homeopathic database.[49]

COMPUTER REPERTORY.

Synthesis is the repertory linked to Radar, the leading homoeopathic software.[31]

Computer repertory is a useful electronic device, which facilitates the process of locating the rubrics and finding out the final indicated medicine or a group of medicines in no time. Search of a rubric, comparison with other repertories, reference to Materia Medica and cross repertorization have become easy and no time consuming with the help of computer repertories. Several reportorial programs have been worked out for speedy reportorial work.[37]

Computer has played a very important role in making homoeopathic repertories more accessible to learners. Computer repertories have also brought on a drastic change in the subject of homoeopathic repertory by making available more information in one package. [37]

Synthesis is the repertory linked to Radar, the leading homoeopathic software.[31] RADAR is a research and analysis program designed for homeopathic students and professionals. It enables homeopathic practitioners to quickly and easily find symptoms in the Repertory analyze patients cases and find the remedy that is indicated. The user can also browse through thousands of pages of data and find specific information within seconds. The RADAR program contains a fast search engine.[50]

In order to make the world homoeopaths compatible with the changing time, RADAR comes out as compared as the most scientific solution in order to realize the versatility of computerization in homoeopathy.[22]

USE OF COMPUTERS IN HOMOEOPATHY

1. In finding the simillimum, it makes this process more enjoyable and more exciting. It saves the time of writing out all the rubrics and prints it all neatly.
2. It allows in making elimination's, looking at what changes occur this symptom is in, or this out, or put another to a higher-grade etc.
3. Additions to the repertory can be done in a easy way.
4. Real advantage of a computer will be to search through the Materia Medica for symptoms not found in the repertory.
5. Besides the pure repertory work, the computer is an excellent tool to continuously collect information and have it ready to apply in therapy or teaching, to create data banks of solved cases and to be in contact via e.g. Homoeo net with homoeopaths all over the world.[38]

RUBRICS OF SYMPTOMS OF MIGRAINE

Rubrics in Synthesis

MIND - MOANING - hemicrania, with

cop.;1;

MIND - INTOLERANCE - noise, of

am-c.;1; bell.;1; chin.;1; ign.;1; ptel.;1.

VISION - HEMIOPIA - hemicrania, with

lyc.;1;

VERTIGO - CHRONIC - headache; with one-sided

nat-m.;2;

HEAD - PAIN - Sides - one side

acon.;1; aesc.;1; aeth.;1; agar.;2; agn.;1; alum.;3; alum-p.;1; alum-sil.;1; am-c.;1; am-m.;1; ambr.;1; anac.;2; ang.;1; ant-c.;1; ant-t.;1; apis;2; arg-met.;2; arg-n.;3; arn.;2; ars.;2; ars-i.;1; ars-s-f.;1; arund.;1; asaf.;2; asar.;2; aur.;1; aur-ar.;1; aur-i.;1; aur-s.;1; bar-c.;2; bar-i.;1; bar-m.;1; bar-s.;1; bell.;2; bism.;2; borx.;1; bov.;2; bry.;2; bufo;2; cact.;2; calc.;2; calc-i.;1; calc-p.;1; calc-s.;1; calc-sil.;1; camph.;1; cann-i.;1; cann-s.;1; canth.;2; caps.;2; carb-an.;1; carb-v.;1; carbn-s.;1; caust.;1; cham.;2;

chel.;2; chin.;2; chinin-ar.;1; chinin-s.;1; cic.;2; cina;1; cinnb.;1; clem.;1; cocc.;1; coff.;3; colch.;1; coloc.;2; con.;1; cop.;1; corn.;2; croc.;1; crot-h.;1;cupr.;1; cycl.;1; dig.;1; dios.;1; dros.;1; dulc.;1; elaps;1; elat.;1; eug.;1; eup-per.;1; euph.;1; euphr.;1; ferr.;2; ferr-ar.;1; ferr-i.;1; ferr-p.;1; gels.;2; gins.;1; glon.;2; graph.;2; guaj.;2; hell.;1; hyos.;1; ign.;2; ind.;1; iod.;1; ip.;1; iris;1; kali-ar.;2; kali-bi.;2; kali-br.;2; kali-c.;3; kali-i.;3; kali-m.;1; kali-n.;1; kali-p.;3; kali-s.;2; kali-sil.;1; kalm.;1; kreos.;1; lac-d.;2; lach.;2; lact.;1; laur.;2; led.;1; lyc.;2; mag-c.;1; mag-m.;1; manc.;1; mang.;1; meny.;1; merc.;2; mez.;2; mill.;1; mosch.;1; mur-ac.;1; murx.;1; nat-ar.;1; nat-c.;1; nat-m.;1; nat-p.;1; nicc.;1; nit-ac.;1; nux-m.;1; nux-v.;2; olnd.;1; par.;1; petr.;1; ph-ac.;3; phos.;2; phyt.;2; plat.;3; plb.;1; psor.;2; puls.;3; ran-b.;1; ran-s.;1; rheum;1; rhod.;1; rhus-t.;2; rob.;2; ruta;1; sabad.;1; sabin.;1; samb.;1; sang.;2; sars.;3; sel.;1; seneg.;1; sep.;2; sil.;2; sphing.;1; spig.;3; spig.;3; spong.;1; squil.;1; stann.;1; staph.;1; stict.;1; stram.;1; stront-c.;1; sul-ac.;3; sul-i.;1; sulph.;2; syph.;2; tab.;1; tarax.;1; tarent.;1; teucr.;1; thuj.;2; ust.;1; valer.;1; verat.;2; verb.;3; viol-o.;1; viol-t.;1; zinc.;3; zinc-p.;1; zing.;1;

HEAD - PAIN - Sides - left

aloe;1; alum.;1; ambr.;2; ant-c.;2 apis;1; ars.;2; ars-i.;2; asaf.;2; asar.;2;k asc-c.;1; aur-m.;1; bell.;2; bism.;1; bov.;2; brom.;3; bry.;1; calad.;1; calc.;2; calc-p.;1; cann-s.;1; canth.;1; carb-v.;1; carbn-s.;1; caust.;1; cham.;2; chin.;2; chinin-ar.;1; chinin-s.;1; cimic.;1; cina;1; coloc.;2; con.;1; conv.;1; croc.;2; crot-h.;1; cupr.;1; cycl.;2; eup-pur.;1; euph.;2; ferr.;2; ferr-i.;2; fl-ac.;1; graph.;2; guaj.;2; gymno.;1; ham.;1; hydr.;1; ign.;1; iod.;2; kali-c.;2;lac-ac.;1; lac-c.;1; lach.;2; lil-t.;1; lith-c.;1; lob.;2; lyc.;1; mag-c.;2; med.;1; merc.;2; merc-i-f.;1; merc-i-r.;1; murx.;1; nat-m.;1; nit-ac.;2; nux-m.;2; olnd.;2; pall.;1; par.;2; phel.;1; phos.;2; plan.;1; plat.;2; plb.;1; ptel.;1; ran-b.;1; ran-s.;1; rhod.;2; rhus-t.;2; sabad.;1; samb.;2; sec.;1; sel.;2; sep.;3; spig.;3; sulph.;2; tab.;1; tarax.;2; tarent.;1; thuj.;2; trom.;1; verat-v.;1; viol-o.;1; viol-t.;1; xan.;1; zinc.;2; zing.;1;ziz.;1.

HEAD - PAIN - Sides - left - then right

aesc.;1; arn.;1; euon.;1; eup-per.;1; glon.;1; nux-m.;2; squil.;1; sulph.;1

HEAD - PAIN - Sides - right

alum.;2; alum-sil.;1; arg-met.;1; arg-n.;1; ars.;1; asaf.;1; bell.;3; bism.;2; bov.;1; bry.;2; bufo;1; cact.;2; calc.;3; calc-i.;1; calc-sil.;1; carb-an.;1; carb-v.;3; caust.;2; cham.;1; chel.;2; cimic.;1; cina;2; cist.;1; coc-c.;1; coca;1; coff.;1; con.;2; croc.;1; crot-c.;2; crot-h.;1; cycl.;1; euph.;1; ferr-ar.;1; gels.;1; gins.;1; gran.;1; graph.;1; grat.;1; guaj.;1; hep.;2; ign.;3; iod.;1; iris;3; jac-g.;1; kali-c.;1; kali-sil.;1; lach.;1; lyc.;2; mag-c.;1; meny.;1; merc.;1; merc-i-r.;1; mez.;2; mill.;1; mosch.;2; nat-ar.;1; nat-m.;2; nit-ac.;1; nux-m.;1; ol-an.;1; plat.;1; plb.;2; ran-b.;2; rat.;2; rheum;1; rhod.;1; rhus-t.;2; ruta;2; sabad.;3; sang.;2;sep.;3; sil.;1; spong.;1; sulph.;1; tarax.;1; tarent.;1; thuj.;1; urt-u.;1; verat.;1; zinc.;1;

HEAD - PAIN - Sides - right - then left

arn.;1; bry.;1; colch.;1; cupr.;1; dig.;1; merc-i-r.;1; staph.;1; tax.;1;

HEAD - PAIN - Sides - one side - extending to - eye

asaf.;2; brom.;1; caust.;1; croc.;1; mag-m.;1; nat-m.;1;

HEAD - PAIN - Sides - menses - before

calc-p.;1; cinnb.;1; puls.;1;

HEAD - PAIN - Sides - menses - during
am-m.;1; ars.;1; berb.;1; calc.;1; calc-p.;1; castm.;1; chin.;1; cic.;1; colch.;1; cycl.;1; lob.;1;

lyc.;1; mag-c.;1; mag-m.;1; nat-c.;1; nux-v.;1; puls.;1; sang.;2; sep.;1; verat.;1;

HEAD - PAIN - Sides - menses - after
ferr.;2;

HEAD - PAIN - Sides - pulsating
arg-n.;1; ars.;2; aur.;1; bell.;1; brom.;2; cact.;2; calc-p.;1; carb-ac.;1; con.;1; hura;1; kali-

c.;1; laur.;1; nat-c.;1; nit-ac.;2; puls.;1; sec.;1; zinc.;1;

HEAD - PULSATING - Sides - left
am-c.;1; bar-c.;1; calc.;1; chin-b.;1; glon.;1; hura;1; kali-bi.;1; mag-m.;1; nat-c.;1; nit-ac.;2;

phos.;1;

HEAD - PULSATING - Sides - right
aeth.;1; agar.;1; alum.;1; arg-n.;1; aur.;1; cact.;1; con.;1; ferr-p.;1; graph.;1; kali-c.;1;

laur.;1; mag-c.;1; phos.;2; rhod.;1; sang.;1; sul-ac.;1; zinc.;1;

HEAD - PULSATING - transient, in one-half of
cham.;1;

EYE - REDNESS - megrim
kali-br.;2; spig.;2;

EYE - PHOTOPHOBIA - headache, during
ferr-p.;2; kali-p.;1; nat-s.;3; tarent.;1;

EYE - LACHRYMATION - headache, during
agar.;1; apis;1; arg-n.;1; asar.;1;bell.;1; bov.;1; carb-an.;1; carb-v.;1; chel.;1; com.;1;

con.;1; eug.;1; euphr.;1; hep.;1; ign.;2; ind.;1; kali-c.;1; kali-i.;1; lac-c.;1; lach.;1; lil-t.;1;

merc.;1; mez.;1; nat-m.;1; osm.;1; plat.;2; puls.;2; rhus-r.;1; spong.;1; stram.;1; sulph.;1;

tax.;1.

EYE - PAIN - left - headache; with left-sided
apis;1; apis;1.

EYE - PHOTOPHOBIA - headache, during
ferr-p.; kali-p.;1; nat-s.;3; tarent.;1;

VISION - BLURRED - headache, before

gels.;2; hyos.;1; iris;3; kali-bi.;2; podo.;1; sep.;2; sulph.;2.

VISION - COLORS before the eyes - black - rings, circles - headache, before
psor.;2.

VISION - COLORS before the eyes - black - spots - headache - before
phos.;1; psor.;2;

VISION - COLORS before the eyes - black - spots - headache - during
glon.;2;meli.;3.

VISION - COLORS before the eyes - blue - stars - headache, during
psor.;2;

VISION - DIM - left - headache; with right-sided
arg-n.;1;

VISION - DIM - headache - before
gels.;2; hyos.;1; iris;3; kali-bi.;2; lac-d.;2; nat-m.;2; podo.;1; psor.;2; sep.;2; stram.;1.

VISION - DIM - headache - during
anh.;1; ars.;2; asar.;1; aster.;1; bell.;2; caust.;2; cycl.;3; ferr-p.;1; gels.;1; hyos.;1; iris;3;

lac-c.;1; lil-t.;1; mur-ac.;1; nat-m.;2; nit-ac.;1; petr.;2; phos.;2; psor.;2; sil.;2; stram.;2;

sulph.;3; verat-v.;1; zinc.;2.

VISION - FLICKERING - headache - before
aran.;1; graph.;2; iris;1; nat-m.;2; plat.;2; psor.;2; sars.;2; sep.;1; sulph.;2; ther.;1.

VISION - FLICKERING - headache - beginning of

sars.;2.

VISION - FLICKERING - headache - during
chin.;3; chinin-ar.;1; chinin-s.;1; coloc.;2; con.;1; cycl.;3; graph.;1; lach.;2; nat-m.;3;

phos.;2; sars.;1; sil.;2;sulph.;2.

VISION - FOGGY - headache, during
aster.;1; cycl.;2; gels.;1; sulph.;1; til.;1.

VISION - SCOTOMA
aloe;1; carbn-s.;1; tab.;1

VISION - SCOTOMA - central
carbn-s.;1; tab.;1; thyr.;1

VISION - SPARKS - headache - before
carb-ac.;1; chinin-s.;1; coca;1; cycl.;1; eug.;1; lach.;1; phos.;1; plat.;2; psor.;1; sars.;1;

spong.;1; sulph.;1; viol-o.;1;

VISION - SPARKS - headache - during
am-c.;1; ars.;1; chel.;2; mag-p.;3.

VISION - SPOTS - headache - with
cycl.;1;

VISION - SPOTS - headache - before
psor.;2;

VISION - SPOTS - headache - before
psor.;2;

HEARING - ACUTE - headache, during

acon.;1; coff.;1; phyt.;1; phyt.;1.

STOMACH - NAUSEA - headache, during

acon.;1; aesc.;1; ail.;1; alum.;2; alumn.;1; am-c.;2; ambr.;1; ant-c.;3; ant-t.;1; apis;1; arg-met.;1; arg-n.;1; arn.;1; ars.;2; asar.;1; asc-c.;1; aur.;1; aur-s.;1; benz-ac.;1; borx.;2; bry.;2; calc.;1; calc-p.;2; calc-s.;1; camph.;1; cann-s.;1; caps.;2; carb-ac.;2; carb-v.;2; carbn-s.;2; caust.;3; cedr.;2; chel.;1; chin.;1; chinin-ar.;1; chinin-s.;1; cic.;1; cimic.;1; cob.;1; cocc.;3; coloc.;2; con.;3; cor-r.;1; croc.;1; crot-h.;1; cupr.;2; cycl.;1; dros.;1; dulc.;2; epiph.;1; eug.;2; eup-per.;1; eup-pur.;1; ferr.;1; fl-ac.;1; form.;1; gels.;1; glon.;2; graph.;2; grat.;1; hep.;1; hipp.;1; ign.;1; ind.;1; ip.;3; iris;3; kali-ar.;1; kali-bi.;2; kali-c.;2; kali-p.;1; kali-s.;2; kalm.;1; kreos.;1; lac-c.;2; lac-d.;2; lach.;2; lept.;2; lith-c.;1; lob.;2; lyc.;1; mag-c.;1; merc.;2; mez.;1; mill.;1; mosch.;2; nat-ar.;1; nat-c.;1; nat-m.;2; nat-p.;1; nat-s.;1; nit-ac.;2; nux-m.;2; nux-v.;2; op.;2; petr.;1; phos.;2; phyt.;1; plat.;1; puls.;2; ran-b.;1; rhus-t.;1; ruta;1; sang.;3; sars.;2; seneg.;1; sep.;2; sil.;1; spig.;1; stann.;2; stram.;1; stront-c.;1; sulph.;2; tab.;2; tarax.;1; tep.;1; ter.;1; ther.;1; thuj.;1; verat.;1; zinc.;1; zing.;1.

STOMACH - VOMITING - headache, during

aeth.;2; agn.;1; alum.;1; anan.;1; ant-t.;1; apis;2; arg-n.;1; arn.;1; ars.;2; asar.;1; bar-m.;1; bell.;2; bry.;2; cact.;2; cadm-s.;1; calc.;2; calc-s.;1; caps.;2; carbn-s.;1; caust.;1; chin.;1; chinin-ar.;1; chlf.;2; cimic.;1; cimx.;1; cocc.;1; coff.;2; coloc.;1; con.;1; corn.;1; crot-h.;2; crot-t.;1; cupr.;2; dulc.;1; eug.;1; ferr.;1; ferr-ar.;1; ferr-p.;1; form.;2; gels.;2; glon.;1; graph.;2; grat.;2; ip.;3; iris;2; jatr-c.;1; kali-ar.;1; kali-bi.;1; kali-c.;1; kali-chl.;1; kali-p.;1; kali-s.;1; kreos.;1; lac-c.;2; lac-d.;2; lach.;2; lob.;2; med.;1; meli.;3; mez.;1; mosch.;1; naja;2; nat-m.;2; nat-p.;1; nat-s.;2; nux-m.;2; nux-v.;2; op.;1; phos.;2; plat.;1; plb.;2; puls.;3; rhus-r.;1; sang.;3; sarr.;1; sars.;1; sep.;2; sil.;2; spig.;1; stann.;2; stram.;2; sulph.;1; tab.;1; ther.;2; thuj.;1; verat.;1; verat-v.;1; vip.;1; xan.;1; zinc.;1;

EXTREMITIES - PERSPIRATION - Hand - megrim, in

calc.;2;

EXTREMITIES - WEAKNESS - Hand - headache, during

ol-an.;1;

EXTREMITIES - WEAKNESS - Foot - headache, during

ol-an.;1;

GENERALS - WEAKNESS - headache - from

ars.;1; ars-h.;1; bufo;1; calc.;1; cist.;1; cob.;1; fago.;1; glon.;1; kali-c.;1; lac-d.;1; naja;1; pic-ac.;1; sil.;1;

GENERALS - WEAKNESS - headache - during

ant-c.;3; aran.;1; ars-h.;1; ars-h.;1; bism.;1; bufo;1; bufo;1; calc-ar.;1; carb-v.;1; chin.;1; chinin-s.;1; cob.;1; cob.;1; fago.;1; fago.;1; glon.;1; glon.;1; lil-s.;1; lil-s.;1; naja;1; naja;1; sil.;2; thuj.;2; thymol.;1; thymol.;1; verat.;2;

RUBRICS IN HOMEOPATHIC MEDICAL REPERTORY

Eye, REDNESS, megrim, during (2)

2 kali-br, 2 spig

Mind,CONSCIOUSNESS, lose, as if he would megrim, in (1)

2 calc

Mind,RESTLESSNESS, anxious megrim, in (1)

2 aeth

Headache, MIGRAINE, headaches, (59)

1 acon, 3 AGAR, 2 anac, 3 ANT-C, 1 apis, 2 arg-m, 1 arn, 2 ars, 3 ASAF, 2 asar, 1 aur, 1 bell, 3 BRY, 2 cact, 1 calad, 2 calc, 2 calc-p, 1 caust, 1 cedr, 2 cham, 1 chel, 3 CHIN, 1 cic, 1 cimic, 1 cina, 1 cocc, 3 COFF, 1 coloc, 2 eup-per, 3 GELS, 1 glon, 1 graph, 3 IGN, 3 IP, 3 IRIS, 1 kali-bi, 2 kali-p, 1 lac-c, 1 lach, 1 lyc, 3 NAT-M, 2 nat-s, 3 NUX-V, 1 op, 3 PHOS, 3 PULS, 3 SANG, 1 scut, 2 sep, 3 SIL, 1 spig, 2 stram, 2 sulph, 2 tab, 1 tarent, 2 ther, 3 THUJ, 2 valer, 3 ZINC

Headache, MIGRAINE, headaches, anxiety, with (1)

2 caust

Headache; MIGRAINE, headaches, bilious (21)

1 am-pic, 1 anac, 2 arg-n, 1 bapt, 2 bry, 1 cham, 1 chel, 2 chion, 1 cycl, 1 eup-per, 2 ip, 1 iris, 1 lob, 1 merc-s, 2 nux-v, 1 podo, 2 puls, 1 rob, 2 sang, 1 stry, 1 tarax

Headache; MIGRAINE, headaches, day and night (7)

1 bor, 1 caust, 1 kreos, 1 led, 1 rhus-t, 1 sul-ac, 1 viol-t

Headache;MIGRAINE, headaches, day, every (29)

2 ars, 2 bell, 1 calc, 1 cedr, 1 coloc, 1 con, 1 eup-per, 1 form, 1 hep, 1 lach, 1 lyc, 1 mag-c, 1 mag-m, 1 mang, 1 merc-i-r, 1 mur-ac, 2 nat-m, 2 nux-m, 2 nux-v, 1 petr, 1 phos, 1 sabad, 1 seneg, 1 sep, 2 sil, 1 spig, 1 stann, 1 sulph, 1 zinc

Headache; MIGRAINE, headaches, day, at same hour (8)

1 aran, 1 ars, 3 CEDR, 1 cimic, 1 gels, 3 KALI-BI, 1 mur-ac, 1 spig

Headache; MIGRAINE, headaches, day, continues two or three days (1)

1 croc

Headache; MIGRAINE, headaches, day, earlier each day (1)

1 form

Headache; MIGRAINE, headaches, eight days (1)

1 iris

Headache; MIGRAINE, headaches, fourteen days (13)

2 ars, 1 calc, 2 chel, 2 chin, 1 chin-ar, 1 ign, 1 nicc, 1 phyt, 1 psor, 1 puls, 1 sang, 2 sulph, 2 tub

Headache; MIGRAINE, headaches, fourteen days, lasting two or three days

3 FERR

Headache; MIGRAINE, headaches, grief, after (2)

1 ign, 1 nat-m

Headache; MIGRAINE, headaches, injury, head after (1)

1 nat-s

Headache; MIGRAINE, headaches, menses, before (3)

1 lach, 1 sep, 1 zinc

Headache; MIGRAINE, headaches, other day (15)

1 alum, 1 ambr, 1 ars, 1 cact, 2 cedr, 1 chin, 1 cimic, 1 eup-per, 1 merc-c, 1 nat-m, 1 nux-v, 2 phos, 1 psor, 1 sang, 1 sulph

Headache; MIGRAINE, headaches, seven days, every (24)

1 ars, 1 calc, 1 calc-ar, 2 chin, 1 dys-co, 1 epip, 1 eup-per, 1 gels, 2 iris, 2 lac-d, 1 lyc, 1 morg, 1 nux-m, 2 phos, 1 phyt, 1 psor, 1 rhus-t, 1 sabad, 2 sang, 1 sep, 2 sil, 2 sulph, 1 syc-co, 2 tub

Headache; MIGRAINE, headaches, six weeks (1)

2 mag-m

Headache; MIGRAINE, headaches, sunday (1)

1 tub

Headache; MIGRAINE, headaches, ten days (1)

2 lach

Headache; MIGRAINE, headaches, three or four days (3)

1 aur, 1 eup-per, 1 sang

Headache; MIGRAINE, headaches, three days-seven days (1)

1 eup-per

Headache; MIGRAINE, headaches, twenty one days (1)

1 aur

Headache; MIGRAINE, headaches, two-three weeks (1)

1 ferr

Headache; MIGRAINE, headaches, year, every, before winter (1)

1 aloe

Stomach; HICCOUGHS, general migraine headache, in (1)

1 aeth

Hands; PERSPIRATION migrain, in (1)

2 calc

Constitution; WOMEN, hysteric pulsation all over body hemicrania (1)

2 sep

Hearing; NOISES, ringing hemicrania, in (1)

2 chin-ar

Hearing; NOISES, roaring hemicrania, in (1)

2 chen-a

Liver; HEADACHES, liver disordered, with liver complaints, alternates with hemicrania (1)

2 ars

Liver; SHARP, pain hemicrania, in (1)

2 cham

Mind; MOANING, hemicrania, with (1)

1 cop

Eye; REDNESS, megrim, during (2)

2 kali-br, 2 spig

Mind; CONSCIOUSNESS, lose, as if he would megrim, in (1)

2 calc

Mind; RESTLESSNESS, anxious megrim, in (1)

2 aeth

RUBRICS IN PHATAK'S REPERTORY

Migraine (See Head, one sided symptoms):

1 Cahin;1 gels; 1 Ip; 1Kali-bi; 1Lac-d; 1 Nat-m; 1 Nat-s; 1 Onos, 1 Psor; 1 Rob; 2 Sang; 1 Sil; 1 Spig; 1Ther

Migraine (See Head, one sided symptoms):Face, pale, with:

1 Aml-n; 1 Ars

Migraine (See Head, one sided symptoms):Prolonged:

1 Cycl; 1 Lac-d

Migraine (See Head, one sided symptoms):Sleepy, before:

1 Sulph

Migraine (See Head, one-sided symptoms): Sunset Amel:

1 Lac-d

Sleepiness:Migraine, then:

1 Sulph

Head:One sided:

1 alum; 1 anac; 1 Arg-n; 2 Ars; 1 Asaf; Calc; 2 Chin; 2 Chin-s; 1 Coff; 2 Coloc; 1 Con ; 3 Iris; 1 Kali-c; 1 Kali-I; 1 Nux-v; 2 Ph-ac; 1 Plat; 3 Psor; 2 Puls; 1 Sabad; 3 Sang; 1 Sars; 2 Sep; 1 Spig; 1 Sul-Ac; 1 Verb; 1 Zinc

Head:One sided:Begins on one, goes to and Agg., on other:

1 Arg-n; 1 Ferr; 1 Iris; 1 Lac-c;3 Lyc; 1 Mang; 1 Nat-m; 1 Tub

Head:One sided:Right:

2 Bell; 2 Calc; 1 Cact; 1 Carb-v; 1 Chel; 3 Ign;2 Iris; 1 Kalm; 1 Lyc; 1 Nat-c; 1 Plat; 1 Plb; 1 Prun; 1 Puls; 1 Rhus-t;3 Sang;1 Sars; 2 Sabad; 2 Sil;

Head:One sided:Left:

3 Spig; 2 Coloc; 2 Lach; 2 Merc; 2 Nux-v; 2 Rhod; 2 Sep;1 Arn; 1 Ars; 1 Asaf; 1 Brom;1 Chin-s; 1 Ip;1 Kali-c; 1 Lil-t; 1 Mur-ac;1 Naja;1 Nit-ac; 1 Nux-m; 1 Onos;1 Sel;1 Sulph

RUBRICS IN KNERR'S REPERTORY

[Knerr] [Inner Head]Hemicrania (megrim, migraine, semilateral headache):

4 Cham ,4 Sil; 3 Paull; 3 Aeth; 3 Apis; 3 Arg-n; 3 Arn; 3 Ars; 3 Asar; 3 Bar-c ; 3 Bry 3 Calc; 3 Caps; 3 Chen-a; 3 Chin-ar; 3 Coca; 3 Corn; 3 Eup-per; 3 Ferr; 3 Gels;3 Graph; 3 Guai; 3 Indg; 3 Kali-bi; 3 Kreos; 3 Lac-d; 3 Lach; 3 Phos; 3 Rob; 3 Syph ; 3 Verat; 3 Zing; 2 Ant-c; 2 Petr; 2 Rhus-t; 1 Agn; 1 Arum-m ; 1 Aur; 1 Bell; 1 Cann-I; 1 Coff-t;1 Mill; 1 Sin-n; 1 Tarent; 1 Ust

RUBRICS IN BBCR BY C. M. BOGER

Head - Location: HALF OF, ONE (MIGRAINE ETC.)

1 acon, **3 AGAR,** *2 agn,* **3 ALUM,** 1 am-c, *2 am-m,* **3 ANAC,** 1 ang, 1 ant-c, *2 ant-t,* **3 ARG,** *2 arg-n, 2 arn, 2 ars,* **3 ASAF,** *2 asar,* 1 aur, **3 BAR-C,** *2 bell,* 1 bism, 1 bor, *2 bov,* 1 bry, 1 calc-acet, **3 CALC,** 1 camph, 1 canch, **3 CANTH,** 1 caps, 1 carb-an, *2 carb-v, 2 caust, 2 cham, 2 chel,* **3 CHIN,** 1 chin-s, *2 cic,* 1 cimic, **3 CINA,** 1 clem, **3 COCH,** *2 coff,* 1 colch, **3 COLOC,** 1 con, *2 croc,* 1 cupr, **3 CYCL,** *2 dig,* 1 dros, **3 DULC,** 1 eup-per, 1 euph, 1 euphr, 1 ferr, *2 gels, 2 glon, 2 graph,* **3 GUAI,** *2 hell, 2 hep,* 1 hyos, *2 ign,* 1 iod, *2 ip, 2 kali-bi,* **3 KALI-C,** 1 kali-c, *2 kreos,* 1 lac-d, 1 kreos, *2 laur, 2 led,* 1 lil-t, *2 lyc, 2 mag-c, 2 mag-m,* **3 MANG,** *2 marr,* 1 meli, *2 menth, 2 merc,* **3 MEZ,** 1 mosch, **3 MUR-AC,** *2 nat-c,* **3 NAT-M,** *2 nit-ac, 2 nux-m,* **3 NUX-V, 3 OLND,** 1 onos, **3 PAR,** 1 petr, **3 PHOS, 3 PH-AC,** 1 pic-ac, **3 PLAT,** *2 plb,* 1 prun, **3 PULS,** 1 ran-b, 1 ran-s, 1 rheum, *2 rhod,* 1 rhus-t, 1 ruta, **3 SABAD, 3 SABIN,** 1 samb, **3 SANG, 3 SARS,** *2 squil,* 1 sec, 1 sel, 1 seneg, **3 SEP,** *2 sil,* **3 SPIG,** *2 spong, 2 stann,* **3 STAPH, 3 STROPH,** 1 sulph, **3 SUL-AC,** 1 tab, *2 tarax,* 1 ter, *2 thuj,* 1 valer, 1 verat, **3 VERB,** 1 viol-o, 1 viol-t, 1 vip, **3 ZINC**

Head - MIGRAINE: (22)

3 ARS, *2 asar,* 1 bell, 1 bry, **3 CALC,** 1 caps, *2 cham,* **3 CHIN,** *2 chin-s,* **3 COCH, 3 COLOC,** 1 guai, *2 ign, 2 ip, 2 lyc,* 1 merc, **3 NUX-V,** 1 prun, **3 PULS, 3 SANG, 3 SEP,** 1 sil

RUBRICS IN BOERICKE REPERTORY

***Head* HEADACHE TYPE, MIGRAINE, MEGRIM, NERVOUS (51)**

2 am-c, **3 ANAC, 3 ARG-N,** *2 aspar,* **3 BELL,** *2 bry,* **3 CALC-ACET,** *2 calc,* **3 CANN-I,** *2 carb-ac, 2 cedr, 2 chion,* **3 CIMX, 3 COCC, 3 COFF,** *2 crot-c,* **3 CYCL, 3 GELS, 3 IGN,** *2 indg,* **3 IRIS,** *2 kali-bi,* **3 KALI-C, 3 LAC-D, 3 LACH, 3 MELI, 3 MENIS,** *2 nat-m, 2 nicc,* **3 NUX-V, 3 ONOS,** *2 paull, 2 plat-m,* **3 PULS, 3 SANG, 3 SCUT, 3 SEP,** *2 sil, 2 spig, 2 stann, 2 sulph, 2 tab, 2 thea, 2 ther, 2 verb,* **3 ZINC-S,** *2 ziz, 2 aven, 2 anh,* **3 EPIP, 3 ZINC-VAL**

***Head* HEADACHE LOCATION, SEMILATERAL, HEMICRANIA (27)**

2 arg-n, **3 ARS, 3 BELL, 3 BRY,** *2 cedr, 2 cham,* **3 COFF,** *2 coloc,* **3 CYCL,** *2 insulin, 2 glon,* **3 IGN,** *2 kali-bi, 2 lach, 2 nat-m, 2 ol-an,* **3 ONOS,** *2 phos, 2 prun,* **3 PULS, 3 SANG,** *2 sep,* **3 SIL, 3 SPIG, 3 STANN,** *2 thuj, 2 joan*

RUBRICS IN CLARKE'S REPERTORY

[Clarke] [Clinical]Migraine:

2 Aur-br; 2 Brom; 2 Coff-t; 2 Dam; 2 iris; 2 Juc-c; 2 Nat-s; 2Nic; 2 Ol-an; 2; Prim-v; 2 Stict; 2 Tarent; 2 tong; 2 zinc

MATERIALS AND METHODS

This study on Migraine was conducted in patients who visited Homoeopathic out Patient Department of Fr. Muller Homoeopathic Medical College. Samples of 30 cases were selected from both sexes and with age group ranging between 10 to 50 years. The diagnosis was made on the basis of clinical presentation, using diagnostic criteria and the sampling technique is purposive sampling, The Data has been collected by a structured interview schedule

Inclusion criteria:

This study includes both the sexes of varying age groups with their informed consent. The group of the patients are selected from both sexes between 10 to 50 years of age groups. Diagnosis based on International Headache Society Diagnostic Criteria. The data was collected from patients by interviewing the patients and by clinical examination.

Exclusion criteria:

Cases with associated serious conditions like Myocardial infarction, Renal failure, Hepatic failure and cases with advanced pathological conditions are excluded from the study.

Materials:

The materials taken for this study are,

1 Standardized Case Record.

2 Master chart

3 Computerized repertory chart

4 Repertory: synthesis

All the data were recorded in Standardized case record with the following steps given below.

1 Case taking

2 Recording and interpretation

3 Analysis of the case

4 Synthesizing the case

5 Erecting totality

6 Repertorization

All the cases are simultaneously repertorized in synthesis Repertory

The prescription was arrived by analyzing the higher matched and graded medicines in the repertorized chart of Synthesis repertory and finally these medicines are consulted in Homoeopathic Materia Medica.

The potency selection and repetition of doses were done according to the demand of the case, with the consideration of potency selection criteria such as Susceptibility, Sensitivity, Vitality, Suppression (if any), changes in structural and functional level and the degree of correspondence to the remedies selected.

Follow-ups:

An assessment of all the patients were done before the treatment and the second assessment done after two weeks till a period of minimum 5 to 6 months.

Assessment of effectiveness:

For an effective evaluation and assessment, disease intensity was graded in every patient based on their presentation observed during case taking. After completion of the study, the post treatment disease scores were compared with the pre treatment disease intensity scores and statistically evaluated.

OBSERVATION AND RESULTS

A sample of thirty cases from the patients who attended the Out Patient Department, of Fr. Muller Homoeopathic Medical College and Hospital was taken for this study. All the thirty cases were followed up for a period of five to six months. These cases were subjected to statistical study. The following tables reveal the observation and result of this study.

Table No.9: Distribution of cases according to their Age:

Age (in years)	Number of cases	Percentage
11 – 20	6	20 %
21 – 30	10	33.33 %
31 – 40	12	40%
41 – 50	2	6.66 %
Total	30	100%

The age of the sample varies from 11-50 years. Among this maximum number of cases 12 patients (40%) were noted in the age group of 31-40 years and in the age group of 21-30 years 10 (33.33%) cases. The next higher incidence of age group is in 11-20 years with 6 patients (20%). This is followed by the age group 41- 50 years with 2 patients (6.66%)

Table No.10: Distribution of cases according to their Sex

Sex	Number of cases	Percentage
Female	23	76.66%
Male	07	23.33%
Total	30	100%

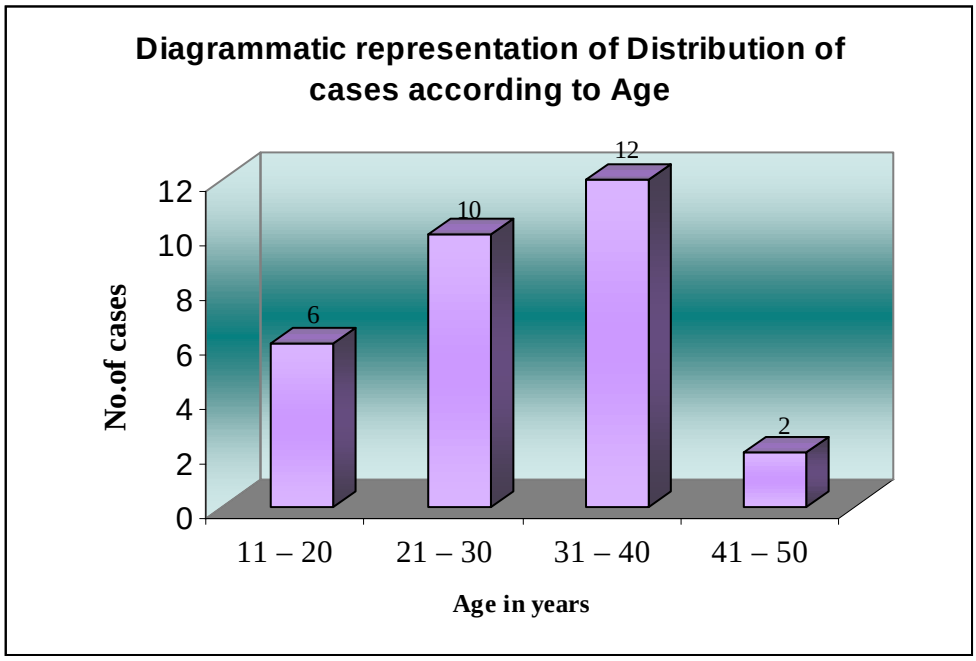


Figure. No.2

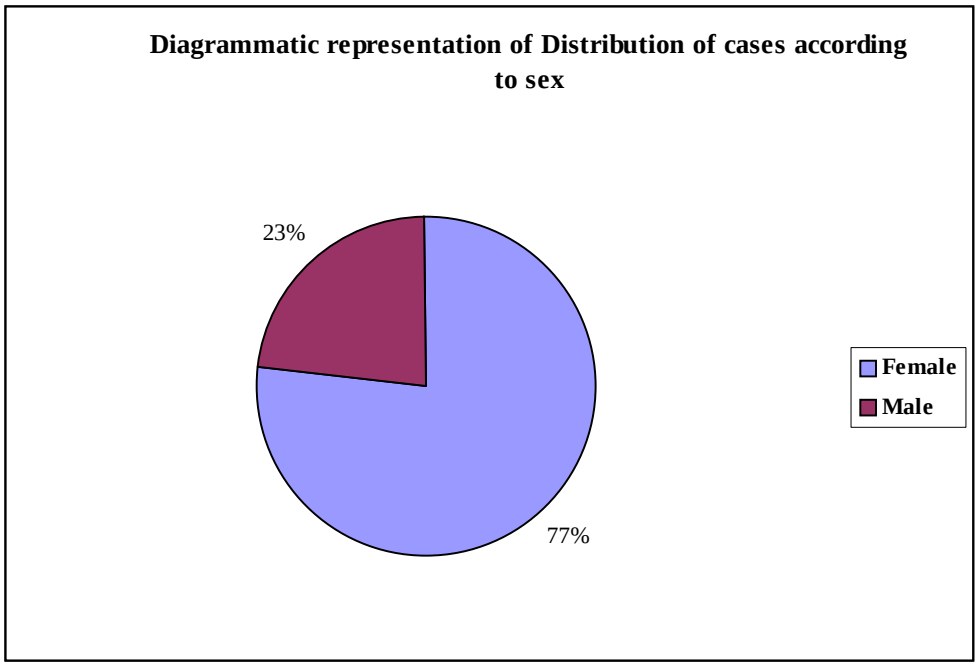


Figure.No.3

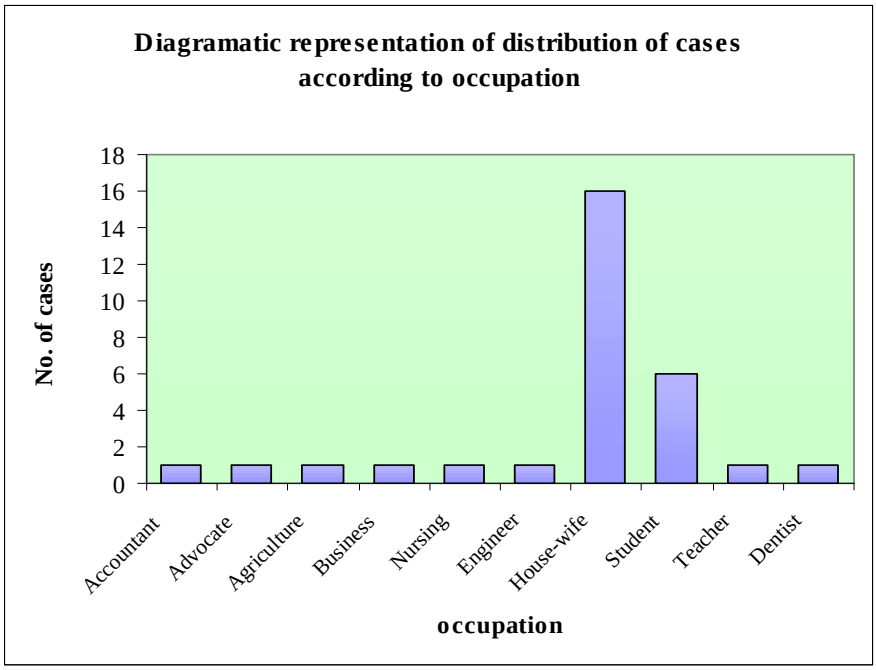
In these thirty cases 7 patients were males with a percentage of 23.33% and 23 patients were females with a percentage of 76.66%. The male and female ratio is 3:1.

Table No.11: Distribution of cases according to their Occupation

Occupation	Number of cases	Percentage
Accountant	1	3.33%
Advocate	1	3.33%
Agriculture	1	3.33%
Business	1	3.33%
Nursing	1	3.33%
Engineer	1	3.33%
House-wife	16	53.33%
Student	6	20%
Teacher	1	3.33%
Dentist	1	3.33%

Total	30	100%

Out of thirty cases the maximum number of cases 16 (53.33%) are housewives; the next higher cases are students as 6 (20%). This is followed by Business, accountant, Advocate, dentist, nursing staff, Engineer, teacher and agriculturist 1 (3.33%) each.



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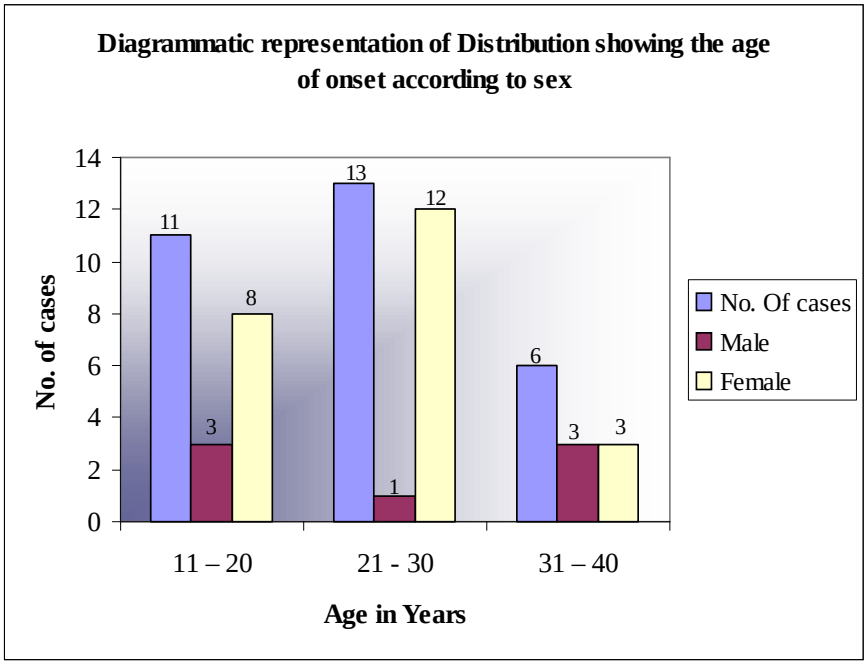

Figure.No.5

Table No. 12: Distribution showing the age of onset according to sex.

Age of onset	No. Of cases	Percentage	Male	Percentage	Female	Percentage
11 – 20	11	36.6%	3	10%	8	26.6%
21 - 30	13	43.3%	1	3.3%	12	40%
31 – 40	6	20%	3	10%	3	10%
Total	30	100%	7	23.3%	23	76.6%

Out of the 30 cases, 11(36.6%) cases had their complaints started between the age of 11-20 years in that 3(10%) were males and 8(26.6%) were females, the age group of 21- 30 showed 13(43.3%) cases as 12(40%) females and 1(3.3%) male. The age group between 31- 40 showed 6 (20%) cases of 3 (10%) cases each as males and females.

Table No. 13: Distribution of cases according to their Complaints

Clinical features	Number of cases	Percentage
Unilateral	24	80 %
Throbbing/ pulsing	20	66.6 %
Nausea	25	83.3%
Photophobia	03	10 %
Phonophobia	06	20%
Blurring of vision	13	43.33%
Activity makes it worse	05	16.66%
Vomiting	15	50%

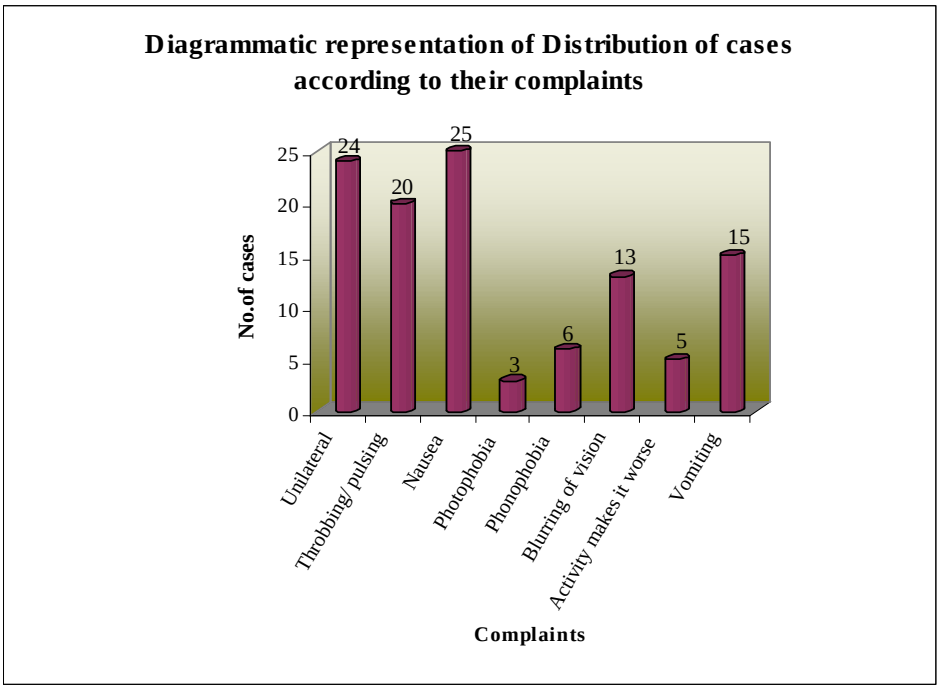

Figure.No.6

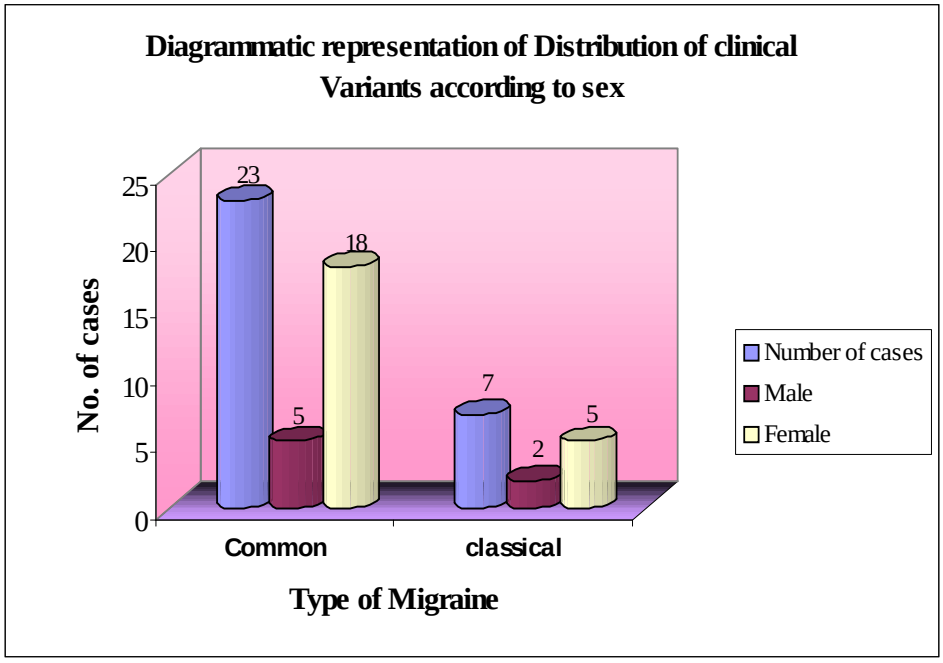

Figure.No.7

In these thirty cases the most common complaints were unilateral headache in 24(80%) patients, pain of throbbing nature in 20 (66.6%) patients. 25 (83.3%) patients reported nausea and 15 (50%) had Vomiting. Out of thirty 13 (43.3%) patients had Blurring of vision and 3 (10%) patients had Photophobia.6 (20%) patients had Phonophobia. 5 (16.6%) had complaints aggravated by exertion.

Table No.14. Distribution of Clinical variants according to sex

Type	Number of cases	Male	Female
Common Migraine (Migraine with out Aura)	23(76.6%)	5(16.6%)	18(60%)
Classical Migraine (Migraine with Aura)	7(23.3%)	2(6.66%)	5(16.6%)
Total	30(100%)	7(23.3%)	23(76.6%)

In the 30 cases 23(76.6%) cases were common migraine in that 18(60%) were females and 5(16.6%) were males. 7 cases (23.3%) were classical migraine, in that 5(16.6%) were females and 2(6.6%) were males.

Table No. 15: Distribution showing the Duration of treatment according to sex

Duration of treatment (In months)	No. of cases	Percentage	Male	Percentage	Female	Percentage
5 - 9	20	66.6%	6	20%	14	46.6%
10 – 14	4	13.3%	0	0%	4	13.3%
15 - 19	6	20%	1	3.3%	5	16.6%
Total	30	100%	7	23.3%	23	76.6%

In this study group, 20 (66.6%) cases were followed for 5- 9 months. Among these 6(20%) were males and 14 (43.3) were females. 4(13.3%) cases were followed for

10 – 14 months. In this group all 4(13.3%) were females. 6(20%) cases were followed for 15 – 19 months, and in this 5(16.6%) were females and 1(3.3%) male

Table No. 16: Distribution of cases according to their constitutional Remedies

Remedies	**Number of cases**	**Percentage**
Calc carb	2	6.6%
Kali carb	2	6.6%
Lachesis	1	3.3%
Lycopodium	1	3.3%
Natrum mur	12	40%
Natrum sulph	1	3.3%
Nux Vomica	1	3.3%
Pulsatilla	3	10%
Sepia	1	3.3%
Silicea	4	13.3%
Sulphur	2	6.7%
Total	30	100%

In all thirty cases constitutional remedies were prescribed. Based on constitutional totality Natrum mur. indicated in maximum number 12 (40%) of cases and proved to be effective., Silicea indicated in 4(13.3%) cases , Pulsatilla indicated in 3(10%) cases. Calc.carb, Kali carb and Sulphur were given to 2 (6.6%) cases each, Lachesis, Lycopodium, Natrum sulph, Nux vomica, Sepia were given in 1 (3.3%) case each.

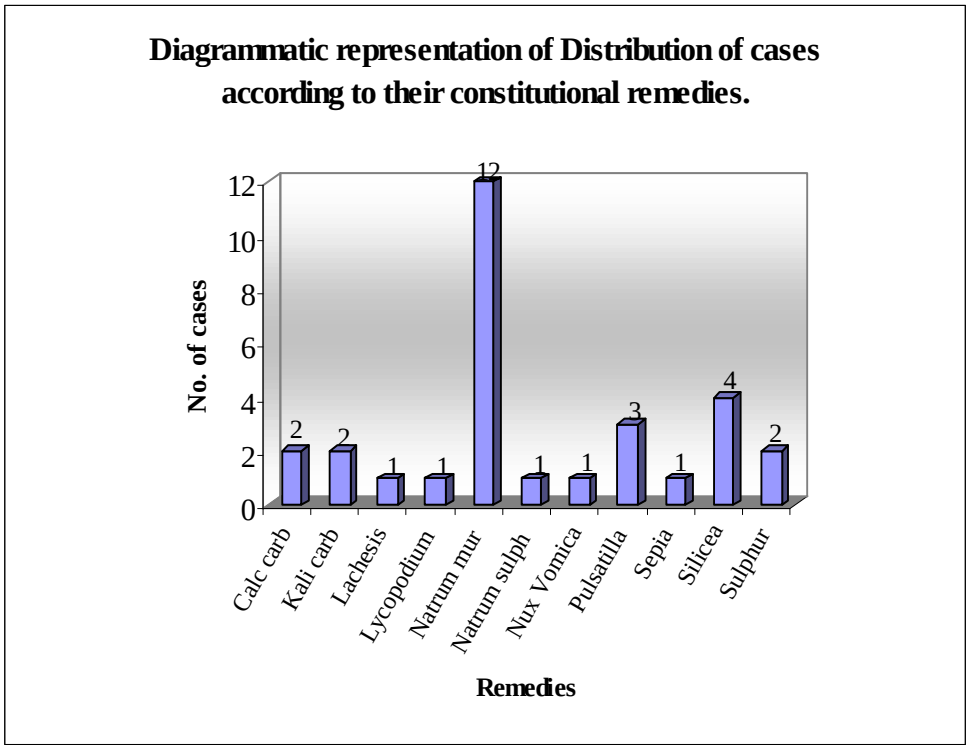

Figure.No.8

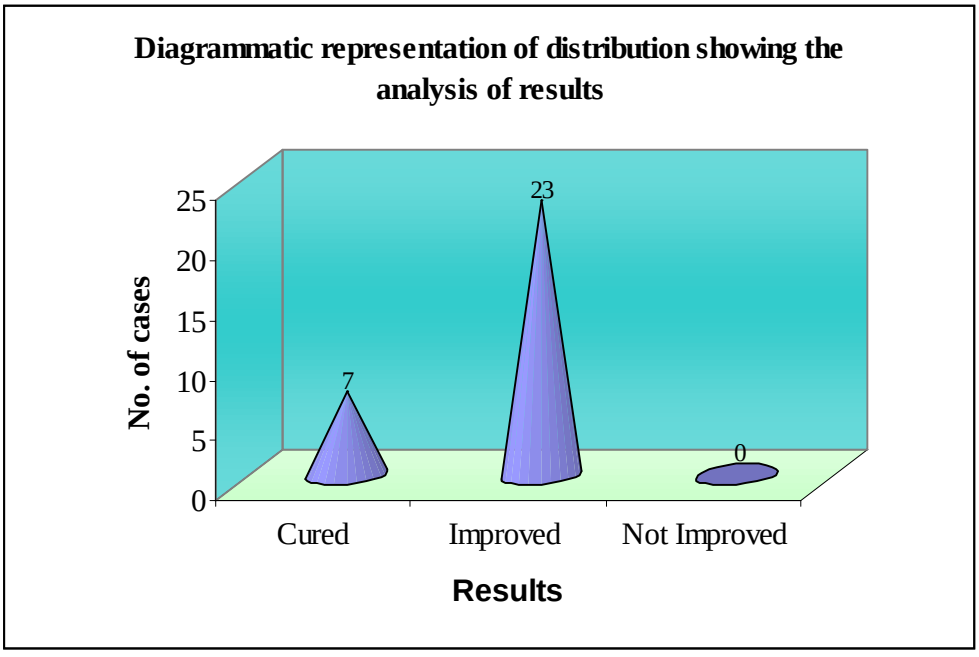

Figure.No.9

Table No.17: Distribution showing the analysis of result.

Analysis	Number of cases	Percentage
Cured	7	23.3%
Improved	23	76.6%
Not Improved	0	0%
Total	30	100%

In the thirty cases followed up all the cases showed good improvement. In that 7(23.3%) cases were completely cured.

Table No.18: Statistical Analysis

Case. No	X	Y	X-Y= Z	(Z-Z')	$(Z-Z')^2$
1	7	1	6	0.8	0.64
2	5	1	4	-1.2	1.44
3	7	1	6	0.8	0.64
4	7	1	6	0.8	0.64
5	6	1	5	-0.2	0.04
6	6	0	6	1.8	0.64
7	6	1	5	-0.2	0.04
8	7	0	7	0.8	3.24
9	6	1	5	-0.2	0.04

10	7	1	6	0.8	0.64
11	6	2	4	-1.2	1.44
12	6	1	5	-0.2	0.04
13	7	1	6	0.8	0.64
14	7	1	6	0.8	0.64
15	7	2	5	-0.2	0.04
16	7	0	7	1.2	1.44
17	6	0	6	0.8	0.64
18	6	1	5	-0.2	0.04
19	7	2	5	-0.2	0.04
20	6	2	4	-1.2	1.44
21	5	2	3	-2.2	4.84
22	7	1	6	0.8	0.64
23	7	1	6	0.8	0.64
24	7	1	6	0.8	0.64
25	6	2	4	-1.2	1.44
26	7	3	4	-1.2	1.44
27	7	2	5	-0.2	0.04
28	6	2	4	-1.2	1.44
29	7	2	5	-0.2	0.04
30	6	2	4	-1.2	1.44
Total	194	38	$\sum Z = 156$		$\sum (Z-Z')^2 = 27$

X= Score before treatment

Y= Score after treatment

Z= Mean difference

$Z' = 156 / 30 = 5.2$

A. Questions to be answered

- Is there any difference between the scores taken before the treatment and scores after the Homoeopathic treatment

B. Null Hypothesis:

There is no difference between the scores before and after the Homoeopathic treatment

C. Standard error of the mean differences

The mean of differences $Z' = \sum Z/n = 156 / 30 = 5.2$

The estimate of population standard deviation is given by $Sz = \sqrt{\sum(Z-Z')^2 / n-1}$

Hence $Sz = \sqrt{27/29} == 0.96$

The estimate of standard error of mean = $Sz / \sqrt{n} = 0.96 / 5.3 = 0.181$

D. Critical ratio = $t = \frac{Z'}{Sz/\sqrt{n}} = 5.2 / 0.181 = 28.72$

E. Comparison with tabled value

Thus the critical ratio t follows a distribution with n-1 degrees of freedom. The 5% level is 2.045 and 1% level is 2.756 for 29 degrees of freedom. Since the Calculated value 28.72 is greater than the tabled value at 5% and 1% level, The null hypothesis is rejected

F. Inference

This study provides an evidence to say that; there is significant reduction in the disease intensity scores after the homoeopathic treatment with the use of synthesis repertory is effective in the treatment of migraine. Therefore Homoeopathic treatment of Migraine with Synthesis repertory is one of the best methods for controlling the disease condition.

DISCUSSION

The subjects of study were selected from those patients with migraine attending homoeopathic out patient department of Fr. Muller homoeopathic medical college, as per the inclusion criteria. A total of 30 cases were selected and followed up for a period of five to six months, but a few cases which had not completed the above said time period, also were considered for the analysis. Selected cases were between the age group of 10-50 yrs. The cases were diagnosed based on clinical presentation using international headache society diagnostic criteria

This study was conducted to show the effectiveness of the Homoeopathic medicines selected by repertorizing the cases through *Synthesis* repertory. All the cases were repertorized with synthesis and close running remedies were finally differentiated with further reference to Materia Medica. The acute episodes were treated with acute medicines according to acute totality and chronic constitutional medicine was given after repertorization for further improvement.

Assessments of all patients were done before the treatment and after the treatment. Cases were reviewed at regular intervals. Follow up criteria's been adapted for assessing the changes observed.

The statistical analysis such as, distribution of cases according to age, sex, occupations were calculated and interpreted. The prominent clinical features were one-sided headache of pulsating nature, nausea, vomiting, blurring of vision, photophobia. A disease intensity scoring was done to evaluate the improvement, taking the symptoms as parameters. The scores were put, both before and after treatment statistical test was applied.

In this study maximum number of 12 patients were found to be with in the age group of 31-40 (40%), and 10 patients in the age group of 21-30 (33.3%), this is followed by 6(20.0%)

patients with in the age group of 11-20 and 2 patients (6.6%) in the age group of 41-50 yrs. Here the peak incidence goes to the young adults and middle-aged people.

There was a significant difference in incidence of migraine cases according to both the sexes. Majorities of cases of study group were females. Out of 30 cases studied, 23 (76.6%) patients were found to be females and 7 (23.3%) patients were males.

In this study out of 30 cases, the maximum numbers of cases were housewives as 16 (53.3%), followed by students as 6 (20%) cases. This is followed by Businessperson, accountant, Advocate, dentist, nursing staff, Engineer, teacher and agriculturist 1 (3.33%).

Out of the 30 cases, 23 were common migraine making it up to 76.6% of total cases in that 18(60%) were females and 5(16.6%) were males. 7 cases (23.3%) were classical migraine, in that 5 (16.6%) were females and 2(6.6%) were males

In these thirty cases studied the most common complaints were unilateral headache in 24(80%) patients, pain of throbbing nature in 20 (66.6%) patients. 25 (83.3%) patients reported nausea and 15 (50%) had Vomiting. Out of thirty 13 (43.3%) patients had Blurring of vision and 3 (10%) patients had Photophobia.6 (20%) patients had Phonophobia. 5 (16.6%) had complaints aggravated by physical exertion.

Out of the 30 cases, 11(36.6%) cases had their complaints started between the age of 11-20 years in that 3(10%) were males and 8(26.6%) were females, the age group of 21- 30 showed 13(43.3%) cases as 12(40%) females and 1(3.3%) male. The age group between 31- 40 showed 6 (20%) cases of 3 (10%) cases each as males and females.

All the cases were repertorized in *synthesis 7.1* for obtaining the constitutional remedy. Synthesis is one of the latest repertories, the rubrics are well represented which makes the repertorization easier and quicker with reliable results. Of the 30 cases treated Based on constitutional totality Natrum mur. Indicated in maximum number 12 (40%) of cases and proved to be effective. Silicea indicated in 4(13.3%) cases, Pulsatilla indicated in 3(10%) cases. Calc.carb, Kali carb and Sulphur were given to 2 (6.6%) cases each, Lachesis, Lycopodium, Natrum sulph, Nux vomica, Sepia were given in 1 (3.3%) case each. All the cases showed significant improvement

In this study group, 20 (66.6%) cases were followed for 5- 9 months. Among these 6(20%) were males and 14 (46.6) were females. 4(13.3%) cases were followed for 10 – 14 months. In this group all 4 (13.3%) were females. 6(20%) cases were followed for 15 – 19 months, and in this 5 (16.6%) were females and 1(3.3%) male

In the study group all the patients showed a significant reduction in the post treatment score as compared to the pre treatment score. Out of the 30 cases 7(23.3%) cases cured and

rest all showed a good improvement. This clearly indicates that the homoeopathic treatment is effective in the treatment of migraine

LIMITATIONS

1 Number of samples used in this study is very small. Therefore generalization of the result and inferences of the study need to be done cautiously.

2 This was a time bound study. The cases were followed up only for a period of 5-6 months.

3 Selections of cases were difficult since many of the cases were irregular for reporting and some of them even dropped out.

4 There was no control group since the sample size was small.

5 In some cases necessary information was lacking and the study was based on the available data.

6 There were no standard studies to compare or take guidance from a study of this nature in homoeopathy. Therefore some human errors are expected.

RECOMMENDATIONS:

1. Bigger sample size with extended time of research would provide better results.
2. It will be always scientific if control (placebo) group would have been kept simultaneously to verify the effectiveness of treatment
3. Universal standardized scale can be used, so that evaluation of outcome of the study would become precise.

CONCLUSION

There were a total number of 30 cases taken up at random for the study. Conclusions were arrived after a statistical analysis of patients with migraine.

The following conclusions were drawn from the study

1. The prevalence of migraine is more in females (76.6%) than in Males (23.3%)
2. Majority of the patients belongs to age group of 31-40 years 12(40%) cases, and in 21-30 years group 10(33.3%) cases.
3. Natrum mur. is the leading constitutional remedy administered, in maximum number 12 (40%) of cases.

4. A detailed case taking and evaluation is necessary for the management of these cases.
5. A general improvement in the condition of these patients was noted after the administration of homoeopathic remedies.
6. Constitutional treatment approach is more effective than acute remedies in treating Migraine
7. Bell., Bry, Iris v, Nux.V, spigelia and sang, are the medicines found to be effective in acute management of Migraine
8. Psora is the dominant Miasm in the majority of cases of Migraine
9. The disease intensity scores used for assessment of effect of treatment showed significant reduction after the treatment. 7(23.3%) cases cured and others showed good improvement.
10. Synthesis is one of the best and latest repertory, and found to be useful in finding the simillimum in treatment of migraine.

SUMMARY

This study shows the different presentations of migraine and help to understand the migraine in a detailed way. In this study, the sex incidence of the disease shows that the disease affects predominantly females. The age incidence in the study showed more people in the age group of 31-40 years and 21-30 years. In this study, common migraine is predominant among the types of migraine. It has been observed in the study that most of the cases presented with psoric manifestations.

All the cases showed good improvement after treatment. Repertorization using synthesis repertory was found to be very effective in finding the simillimum. The result of the treatment in the study reveals that there is broad scope for homoeopathy in the treatment of migraine, as majorities of the patients were relived of their complaints after the treatment.

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ANNEXURES

ANNEXURE-I

DISEASE INTENSITY SCORES FOR EVALUATING MIGRAINE

1. Head pain No Pain-0 Mild-1 **Severe-2**	**2. Nausea** Absent-0 Present-1
3. Vomiting Absent-0 **Present-1**	**4. Visual Symptoms** Absent-0 **Present-1**

5. Phonophobia Absent-0 Present-1	**6. Associated Complaints** Absent-0 **Present-1**
7. Aggravation after Exertion Absent-0 Present-1	**8. Aura Symptoms** Absent-0 Present-1

ANNEXURE - II
CASE

FR. MULLER HOMOEOPATHIC MEDICAL COLLEGE AND HOSPITAL

STANDARDISED CASE RECORD

Preliminary data.

Name: Ms. D Age: 19Yrs. Sex: Female. Education: BPT Occupation: Student

Marital status: single Religion: Christian

Father: Living Mother: living

Brother: 0 Sisters: 2

Address: Mangalore

Date of visit: 20-05-03 O.P.D. Reg. no: 15680/03

A.PRESENT HISTORY:

1.Chief complaints (s)

Location.	**Sensation.**	**Modalities. A.F, <, >.**	**Accompaniments.**

1. Head Since 2 Yrs. Forehead & Temples Increased since 1 month. One Sided On & off. Frequency twice a month	Pain Pulsating type[2]	< Evening [3] < Exposure to sun [3] < night [2] > Sleep [2] < Noise	Weakness [2] Eye pain [2] Nausea [3] Dim Vision[2]

History of present complaint:

Patient came with the history of headache, which is one sided with pain in eyes and nausea, headache starts in one side and sometimes spreads over whole head, since 2 yrs and increased since 1 months. The pain is sudden in onset and continuous in nature, lasts more than 7-8 hrs which is aggravated with sun exposure, noise, ameliorated after sleep. There is no radiation of pain to any other area. There is no history of injury, fall etc.

Past history with treatment history

No significant past history. Taken allopathic treatment for headache.

Family history

Mother - Migraine

No other relevant family history

Patient as a person. (Physical generals)

Appearance: Stocky.

Appetite: Good.

Thirst: Good, 4-5 Glasses of water/ day. Prefers cold water

Cravings: Fish[2], Sweets[2]

Aversions: Vegetables [2]

Stool: Regular, Once/ day.

Urine: Regular, 3-4 times/day.

Menstrual function: F.M.P. 12yrs LMP.07-05-03

Menses: Regular Cycle: 30 Day Duration: 3-4 Days

Quantity: Moderate Co lour: Dark-Red Clots: +

Life space investigations:-

Patient hails from a middle class family. Patient is a student studying physiotherapy. Her father is a government employee. She has one elder and a younger sister. Her relationships with family members are good.

By nature she is short tempered. Patient gets angry for simple things and shouts at others[2]. She likes company, and shares some of her problems with friends, but not everything. Whenever she has some problems she weeps, but she never weeps in front of others. Now the patient is staying in hostel for first time, she feels homesick and getting dreams of family members

She has fear of dogs and snake. She has stage fear, before any Programme or appointment, she easily becomes nervous and gets palpitation and sweating, and because of this she avoids all stage programs.

Mental state: -

1.Emotional state

Easily Irritable [2] shouts in anger.

Weeping[2] When alone

Fear of snakes and dogs[2]

Anticipatory anxiety

2.Intellectual state:

Memory – Sharp

Perception – Clear

Thinking – Active

3.Reaction: A.F. <, > state effects.

Likes Company

Consolation Agg

Sleep: 11 P.M. – 6A.M.

Good

Reactions: physical Factors

Desires - Fan in all seasons

Prefers - open air

Bathing - likes cold water.

Seasons - Likes winter season.

Thermal: Hot patient.

General physical examination.

Built and nourishment: Moderately built and nourished

Height: 163 cms.

Weight: 50 kgs.

Pallor: Absent.

Cyanosis: Absent.

Clubbing: Absent

Jaundice: Absent

Lymphadenopathy: No generalized or localized lymphadenopathy

Vital signs:

Temperature: Afebrile Pulse rate: 79/min Respiratory rate: 18/min

Blood pressure: 120/80mm of Hg.

Systemic examination.

Central Nervous System.

Nothing abnormally detected

Respiratory system.

Upper respiratory tract.

Paranasal sinuses: No Tenderness over sinuses.

Lower respiratory tract.

Normal vesicular breath sounds heard, no added sounds

Cardio vascular system:

Nothing abnormally detected

Provisional diagnosis and differential diagnosis.

P/D: Common Migraine

D/D: Sinusitis

Ruled out as there are no symptoms like Postnasal discharges, or nasal symptoms, no tenderness over the sinuses.

Chronic constitutional totality

Mental generals

- Easily angered [2]: Shouts in anger
- Weeping[2]: only when alone.
- Fear of dogs [2]

> Company [2]: Likes to be with friends.

< Consolation [2]:

Physical generals

- Appearance: Stocky.
- Cravings: Fish [2], Sweets[2].
- Aversions: Vegetables [2].
- Thirst- cold water for

Characteristic particulars

Head pain Temples Pulsating [2]

One sided

< Evening [3]

< Night [3]

< Exposure to sun [3]

Nausea[2]

Vomiting [2]

Weakness [2]

> Sleep [2]

Vision blurring headache during[2]

Acute totality

Head, pain Temples [2]

One sided pulsating type

< Evening [3]

< Night [3]

< Exposure to sun [3]

> Sleep [2]

Weakness [2]

Nausea[2]

Vision blurring headache during[2]

Intercurrent totality

Fundamental miasm: Psora.

Dominant miasm: Psora

Repertorial totality

No	Symptom	Rubric	Comment

1.	Easily Angered	MIND - ANGER - easily	Mental general.
2.	Fear of dogs	MIND - FEAR - dogs, of	Mental general.
3.	Shouts When angry	MIND - SHRIEKING - anger, in	Mental general.
4.	Weeps	MIND - WEEPING - alone, when	Mental general.
5.	Likes cold water	GENERALS - FOOD and DRINKS - cold drink, cold water - desire	Physical general.
6.	Desire- Fish.	GENERALS - FOOD and DRINKS - fish - desire	Physical general.
7.	Desire- Sweets.	GENERALS - FOOD and DRINKS - sweets - desire	Physical general.
8.	Aversion - Vegetables.	GENERALS - FOOD and DRINKS - vegetables - aversion	Physical general.
9.	Headache < Evening	HEAD - PAIN - evening	Characteristic- Particulars.
10.	Headache, < Night	HEAD - PAIN - night	Characteristic- Particulars.
11.	Headache, Pulsating type	HEAD - PAIN - pulsating	Characteristic- Particulars.
12.	Headache, < sun.	HEAD - PAIN - sun, from exposure to	Characteristic- Particulars.
13.	Blurring of vision during headache	VISION - DIM - headache - during	Characteristic- Particulars.
14.	Nausea during headache	STOMACH - NAUSEA - headache, during	Characteristic- Particulars.

Repertorial Result:

Nat.mur- 21/12, Phos- 21/11, Bell- 21/9, Sulph- 20/9, Puls- 18/9, chin- 18/8, Lyc-17/7, Caust-16/9, Calc-14/9.

Analysis of the repertorial result:-

Case showed more symptoms suggestive of Nat.mur

- Consolation aggravation

-Thermally Hot

Planning and programming of treatment

S. No.	Define with reasons the states.	Potency- choice	Repetition
1.	Susceptibility: moderate	30-200	Infrequent
2.	Sensitivity: moderate	30-200	Infrequent

3.	Suppressions (if any)	30-200	Infrequent
4.	Correspondence: Const: Rx Total	30-200	Infrequent
5.	Correspondence: Sector Total	30-200	Infrequent
6.	Correspondence: Intercurrent Total	30-200	Infrequent
7.	Functional changes: ++	30-200	Infrequent
8.	Structural changes: Nil	30-200	Infrequent
9.	General vitality: Good	30-200	Infrequent.

First prescription.

1. Nat Mur. 200, 2 p H.S daily.
2. No. ii Pills, 3-3-3, for 1 week.

General management.

- Nutritious diet.
- Avoid over exertion

Follow-up criteria.

1. Appetite.
2. Thirst.
3. Headache.
4. Nausea
5. Vomiting
6. Blurring of vision

Progress notes

< = AGG > = AMEL + = PRESENT S = SAME G =GOOD

A =ABSENT F =FLUCTUATING ↑ = INCREASE ↓ = DECREASE

Date	Symptom changes	Interpretation and expectation	Prescription

3-06-03	Patient generally better. Headache>, Appetite-G, Motion- Regular,	No headache, Marked relief of symptoms, Placebo can be administered	Rx. 1. S.L. packets, 4 packets, 1 packet weekly H.S. 2. No. ii Pills, 3 pills TDS, for 1 month.
05-09-03	Headache ++. Appetite-G, Motion- Regular, Nausea + Weakness < Evening > Sleep	Reappearance of head pain Repetition of constitutional remedy	Rx. 1. Nat. Mur 200 1p H.S. 2. No. ii Pills, 3 pills TDS, for 1 month.
23-09-03	Patient generally better. Headache>, Appetite-G, Motion- Regular,	No headache, Marked relief of symptoms, Placebo can be administered	Rx. 1. S.L. packets, 4 packets, 1 packet weekly H.S. 2. No. ii Pills, 3 pills TDS, for 1 month.
30-09-03	Headache ++. Appetite-↓, Motion- Regular, Nausea +, Vomiting Weakness < Evening > Sleep	Not fully relived of symptoms after the administration of constitutional remedy in a specific potency. Hence Potency was raised	Rx. 1. Nat Mur. 1M, 1P/H.S. 2. No. ii Pills, 3 pills TDS, for 1 month.
11-10-03	Patient generally better. No Headache, Appetite-G, Motion- Regular, Sleep-Good	No headache, Marked relief of symptoms, Placebo can be administered	Rx. 1. S.L. packets, 4 packets, 1 packet weekly H.S. 2. No. ii Pills, 3 pills TDS, for 1 month.
24-12-03	Patient generally better. No Headache, Appetite-G, Motion- Regular, Sleep-Good	Marked relief of symptoms. Placebo can be administered.	Rx. 1 S.L. packets, 4 packets, 1 packet weekly H.S. 2. No. ii Pills, 3 pills TDS, for 1 month.

Summary of the case

Patient named Ms. D aged 19 yrs, female, Physiotherapy student, hailing from Mangalore, came with the complaints of headache, one sided with nausea, vomiting and with blurring of vision since 10 yrs,

in an on and off character. The case is diagnosed as Migraine. The case was taken in detail and was repertorized with *Synthesis* repertory and the constitutional remedy was worked out and it was administered to the patient. Patient is very much better after the treatment.

ANNEXURE - III

MASTER CHART

S.No	Particulars Of the patient	Clinical Diagnosis	Associated complaints	Past & Family History	Miasm	Repertorial Totality	Remedies Administered	Before
1.	Mr.J Age –20 Sex-Female Student Hindu Scr.no-25364/ 04 C/O Head Pain Since 3 yrs Extends from Eyes to vertex pulsating type	Classical Migraine	Sneezing	Fr.-Migraine Mo.- Diabetes Mellitus	F.M.-Sycotic D.M.-Psora	MIND - ANXIETY - future, about MIND - FEAR - happen, something will MIND - OBSTINATE, headstrong HEAD - PAIN - pulsating HEAD - PAIN - sleep - amel. HEAD - PAIN - winter headaches VISION - COLORS before the eyes - dark VISION - DIM - headache - during NOSE - SNEEZING - morning GENERALS - FOOD and DRINKS - butter - desire GENERALS - FOOD and DRINKS - meat - aversion GENERALS - FOOD and DRINKS - sweets – desire	Silicea 1m Sabadilla 30	7
2.	Mrs. F Age-31 Sex-Female Housewife Muslim 11573/ 02 C/O head pain since 2yrs Temples Rt.sided	Common Migraine	Giddiness	Mo.-Hypertension	F.M.-Sycotic D.M.-Psora	MIND - ANXIETY - future, about MIND - ANXIETY - health; about - own health; his MIND - COMPANY - desire for MIND - RESERVED HEAD - PAIN - mental exertion - from HEAD - PAIN - pulsating HEAD - PAIN - Sides - right HEAD - PAIN - sleep - loss of - from late hours HEAD - PAIN - Temples EYE - PAIN - right EYE - TWITCHING - right FACE - PERSPIRATION GENERALS - FOOD and DRINKS - meat - desire GENERALS - FOOD and DRINKS - milk - desire GENERALS - FOOD and DRINKS - spices – desire	Calc.carb 200	5
3.	Mrs.D Age-28 Sex-Female Christian Housewife Scr. No 21153/ 04 Headache One sided With vomiting during head ache Since 10yrs.	Classical Migraine	-	Fr.Diabetes mellitus	F.M.-Sycotic D.M.-Psora	MIND - AILMENTS FROM - grief MIND - BROODING MIND - CONTRADICTION - intolerant of contradiction HEAD - PAIN - Sides - one side HEAD - PAIN - sun, from exposure to MOUTH - TASTE - bitter STOMACH - VOMITING - headache, during DREAMS - DEAD, of the PERSPIRATION - HEADACHE - during PERSPIRATION - ODOR - offensive GENERALS - FOOD and DRINKS - fruit - desire GENERALS - FOOD and DRINKS - meat - desire GENERALS - FOOD and DRINKS -	Nat. Mur 200	7

						sweets - aversion GENERALS - WEAKNESS - headache – during		
4.	Mrs.V Age-30 Sex-Female Housewife Scr.No 17572/ 03 C/oHeadpain Since 10yrs Temples With Nausea Vomiting	Common Migraine	-	-	F.M.-Psora D.M.-Psora	MIND - AFFECTIONATE MIND - IRRITABILITY - headache, during HEAD - PAIN - riding - carriage; in a HEAD - PAIN - sleep - loss of - from late hours HEAD - PAIN - Temples - morning STOMACH - APPETITE - diminished STOMACH - NAUSEA - headache, during STOMACH - THIRST - large quantities, for STOMACH - VOMITING - headache, during GENERALS - FOOD and DRINKS - cold drink, cold water - amel. GENERALS - FOOD and DRINKS - meat - aversion GENERALS - FOOD and DRINKS - pickles - desire GENERALS - WARM - agg.	Sulph-1m Bry-200	7
5.	Mr. D Age-42 Sex-Male Hindu Agriculture Scr.No-25620/ 04 Head pain onesided Extends from forehead to Vertex Since 5 years	Common Migraine	Eructation's Nose block	Mother-Migraine Sister-Migraine	F.M.-Psora D.M.-Psora	MIND - CENSORIOUS, critical MIND - COMPANY - aversion to MIND - CONTRADICTION - intolerant of contradiction MIND - DWELLS - past disagreeable occurrences, on MIND - LOQUACITY MIND - SUSPICIOUS HEAD - PAIN - mental exertion – agg. HEAD - PAIN - sun, from exposure to STOMACH - NAUSEA - headache, during STOMACH - VOMITING - headache, during GENERALS - FOOD and DRINKS - fruit - desire GENERALS - FOOD and DRINKS - meat - desire GENERALS - WEAKNESS - headache – during	Lach-200	6

6.	Mrs.S Age-20 Sex- Female Housewife Hindu Scr.No- 19190/ 03 C/O-Head Pain, one- sided with nausea, Vomiting, Giddiness Since 1 year	Common Migraine	-	-	F.M.- Psora D.M.- Psora	MIND - FEAR alone of being MIND WEEPING alone when DREAMS family on DREAMS EVENTS – Previous-Day of the Previous MIND CONSOLATION Amel. MIND CONTRADICTION Agg. STOMACH APPETITE Diminished GENERALS FOOD&DRINKS Salt Desire GENERALS FOOD&DRINKS Spices Desire PERSPIRATION Profuse HEAD PAIN Forehead HEAD PAIN Pulsating HEAD PAIN Menses during HEAD PAIN Morning HEAD PAIN Night VERTIGO HEADACHE During STOMACH – VOMITING Headache during	Nat-Mur- 200,1m	6
7.	Mr. D Age-40 Sex- Male Hindu Advocate Scr.No- 24904/04 Headpain With nausea and vomiting with perspiratio n in face Since 5 years	Common migraine	-	-	F.M.- Psora D.M.- Psora	MIND - COMPANY - desire for MIND - CONSOLATION - agg. MIND - CONTRADICTION - agg. MIND - IRRITABILITY HEAD - PAIN - mental exertion - from HEAD - PAIN - sleep - amel. HEAD - PAIN - summer FACE - PERSPIRATION STOMACH - NAUSEA - headache, during STOMACH - VOMITING - headache, during GENERALS - FOOD and DRINKS - fish - desire GENERALS - FOOD and DRINKS - sweets - agg.	Nat.Mur 200	6
8.	Mr.D Age -22 Sex – Male Student Scr.no 24579/ 04 Head pain Right sided With nausea vomiting, weakness Since 2 years	Common Migraine	Sneezing		F.M.- Psora D.M.- Psora	MIND - ANXIETY - anticipation; from - engagement; an MIND - ANXIETY - health; about - own health; his MIND - MILDNESS HEAD - PAIN - fasting, from HEAD - PAIN - mental exertion - from HEAD - PAIN - night HEAD - PAIN - noise, from HEAD - PAIN - pulsating HEAD - PAIN - Sides - one side HEAD - PAIN - Temples NOSE - SNEEZING - morning STOMACH - APPETITE - diminished STOMACH - NAUSEA - headache, during GENERALS - FOOD and DRINKS - meat - aversion GENERALS - FOOD and DRINKS - milk - aversion GENERALS - FOOD and DRINKS - sweets – desire	Sil 200	7

9.	Mr.D Age- 27 Sex- Male Christian Dentist Scr. No 20789 / 04 Head pain Throbbing with vomiting Since 15 years.	Common Migraine		Mother – Ca-Breast Hypothyroi dism Hypertensio n Father – Hypertensio n	F.M.- Sycotic D.M.- Psora	MIND - ANXIETY - health; about - own health; his MIND - BROODING MIND - CONSOLATION - amel. MIND - IRRITABILITY - headache, during MIND - TIMIDITY HEAD - PAIN - fasting, from HEAD - PAIN - Sides - one side HEAD - PAIN - Temples - pressure - amel. HEAD - PAIN - Temples - pulsating FACE - PERSPIRATION EXTREMITIES - PERSPIRATION - Hand - palm GENERALS - FOOD and DRINKS - coffee - desire GENERALS - FOOD and DRINKS - sweets - desire DREAMS - SNAKES	Sil 200	6
10.	Mrs.S Age – 33 Sex – Female Housewife Muslim Scr. No 25118/04 Head pain associated with nausea and blurring of vision Photophobi a And Phonophobi a since 6 years	Classical Migraine	Constipat - ion Eructation s	Sister- Migraine	F.M.- Psora D.M.- Psora	MIND - ANXIETY - future, about MIND - ANXIETY - health; about - own health; his MIND - FEAR - alone, of being MIND - FEAR - dark, of HEAD - PAIN - Forehead, in - extending to - occiput HEAD - PAIN - Sides - one side HEAD - PAIN - sleep - amel. HEAD - PAIN - vomiting - amel. EYE - PHOTOPHOBIA - headache, during VISION - DIM - headache - before HEARING - ACUTE - noises, to STOMACH - NAUSEA - headache, during GENERALS - FOOD and DRINKS - sweets - desire	Cal.Carb 200 Nux.Vom.20 0	7
11.	Mr.H Age-40 Sex – male Business Muslim Scr.no. 23879/ 04 C/O Head pain One sided Stitching with nausea and watering in eyes & Sensitive to light Since 10	Common Migraine	-	-	F.M.- Psora D.M.- Psora	MIND MILDNESS MIND BROODING MIND CONFIDENCE want of self confidence MOUTH SPEECH stammering MIND COMPANY Desire for FACE perspiration STOMACH APPETITE diminished HEAD PAIN VETEX extending to head sides of HEAD PAIN VERTEX extending backward HEAD PAIN Stitching HEAD PAIN cold, Head getting cold, on EYES LACHRYMATION headache during GENERALS FOOD&DRINKS Fish desire GENERALS FOOD&DRINKS Meat desire	Nat-Sulph 200	6

	years							
12	Ms.V Age-19 Sex- Female Student Hindu 24443/ 04 Headpain leftsided Throbbing agg.exertio n With nausea and vomiting Since 3 years	Common Migraine	Dysmenor rhea	Mother-Migraine	F.M.-Psora D.M.-Psora	MIND - CONTRADICTION - agg. MIND - FEAR - failure, of MIND - SENSITIVE - opinion of others; to the MIND - SHRIEKING - anger, in MIND - WEEPING - alone, when HEAD - PAIN - exertion - body, etc.; of HEAD - PAIN - mental exertion - from HEAD - PAIN - pressure, external - amel. HEAD - PAIN - pulsating STOMACH - NAUSEA - headache, during STOMACH - VOMITING - menses - before FEMALE GENITALIA/SEX - MENSES - painful, dysmenorrhea GENERALS - FOOD and DRINKS - ice cream - desire GENERALS - FOOD and DRINKS - pungent things – desire	Puls 200	6
13.	Mrs.A Age-40 Sex- Female Housewife Hindu 24676/ 04 Headpain Onesided forehead With nausea Since 10 years	Common Migraine			F.M.-Psora D.M.-Psora	MIND - ANXIETY - future, about MIND - BROODING MIND - MILDNESS MIND - RESERVED HEAD - PAIN - Forehead, in HEAD - PAIN - mental exertion - from HEAD - PAIN - Occiput - extending to - eyes HEAD - PAIN - pulsating HEAD - PAIN - sun, from exposure to EYE - LACHRYMATION - headache, during STOMACH - NAUSEA - headache, during PERSPIRATION - SCANTY sweat GENERALS - FOOD and DRINKS - fish - desire GENERALS - FOOD and DRINKS - hot drinks - desire GENERALS - FOOD and DRINKS - pungent things – desire	Puls 200	7

14.	Mrs.S Age-26 Sex- Female Hindu Housewife Scr.No 19629/ 03 Head pain Pulsating Left sided Agg. Exertion With nausea and vomiting Since 2 years	Common Migraine	Backache		F.M.- Psora D.M.- Psora	MIND - COMPANY - desire for MIND - FEAR - alone, of being MIND - MILDNESS HEAD - PAIN - Forehead, in - left side HEAD - PAIN - reading - agg. HEAD - PAIN - sleep - amel. HEAD - PAIN - sun, from exposure to BACK - PAIN - exertion - from BACK - PAIN - Lumbar region BACK - PAIN - pressure - amel. GENERALS - FOOD and DRINKS - sweets - desire HEAD - PAIN - cold - air – from	Kali carb200	7
15.	Mrs.M Age-28 Sex- Female Housewife Hindu Scr.no 18311/ 04 Headpain Temples, Forehead With blurring of vision, nausea and vomiting since 1 year	Common Migraine	Neck Pain	Sister- Migraine	F.M.- Psora D.M.- Psora	MIND - COMPANY - desire for MIND - CONSOLATION - amel. MIND - MILDNESS HEAD - PAIN - morning HEAD - PAIN - pressure, external - amel. HEAD - PAIN - pulsating HEAD - PAIN - sun, from exposure to VISION - DIM - headache - during STOMACH - THIRSTLESS EXTREMITIES - PAIN - burning - Thigh PERSPIRATION - SCANTY sweat GENERALS - FOOD and DRINKS - eggs - aversion GENERALS - FOOD and DRINKS - fish - aversion GENERALS - FOOD and DRINKS - spices – desire	Sulph 200 Bry 200	7

16.	Ms.D Age-19 Sex- Female Student Christian Scr.no 15680/ 03 Head Pain One sided with eye pain Nausea vomiting and blurring of vision Since 2 years	Common Migraine		Grand mother- Diabetes Mellitus Mother- Allergic rhinitis	F.M.- Sycotic D.M.- Psora	MIND - ANGER - easily MIND - FEAR - dogs, of MIND - SHRIEKING - anger, in MIND - WEEPING - alone, when HEAD - PAIN - evening HEAD - PAIN - night HEAD - PAIN - pulsating HEAD - PAIN - sun, from exposure to VISION - DIM - headache - during STOMACH - NAUSEA - headache, during GENERALS - FOOD and DRINKS - cold drink, cold water - desire GENERALS - FOOD and DRINKS - fish - desire GENERALS - FOOD and DRINKS - sweets - desire GENERALS - FOOD and DRINKS - vegetables - aversion	Nat.Mur 200, 1m	7
17	Mrs.P Age-34 Sex- Female Hindu Housewife Scr.no 16990/ 03 Headache, Unilateral Pulsating with nausea Blurring of vision ad weakness Since 3 years	Common Migraine		Grand Father- Bronchial Asthma	F.M.- Sycotic D.M.- Psora	MIND - ANXIETY - children - about his MIND - IRRITABILITY - menses - during MIND - WEEPING - easily HEAD - PAIN - menses - before HEAD - PAIN - night HEAD - PAIN - pulsating HEAD - PAIN - sleep - amel. VISION - DIM - headache - during FEMALE GENITALIA/SEX - MENSES - clotted FEMALE GENITALIA/SEX - MENSES - late, too DREAMS - DEAD, of the GENERALS - FOOD and DRINKS - meat - aversion GENERALS - FOOD and DRINKS - spices - aversion GENERALS - FOOD and DRINKS - vegetables – desire	Puls 200	6

18	Mrs. A Age-35 Sex- Female Housewife Muslim Scr.No. 24613/ 04 C/O Head pain Forehead right sided with nausea and vomiting Since 8 years	Common Migraine	Vertigo	Elder brother- Diabetes Mellitus Mo.- Hypertensio n	F.M.- Sycotic D.M.- Psora	MIND - YIELDING disposition MIND - BROODING MIND - COMPANY - desire for MIND - CONSOLATION - amel. MIND - CONTRADICTION - agg. MIND - TIMIDITY HEAD - PAIN - sun, from exposure to STOMACH - APPETITE - diminished STOMACH - VOMITING - headache, during GENERALS - FOOD and DRINKS - beans - agg. GENERALS - FOOD and DRINKS - cabbage - agg. GENERALS - FOOD and DRINKS - eggs - desire GENERALS - FOOD and DRINKS - meat - aversion	Sil-1m	6
19.	Mr.M Age-40 Sex-Male Hindu Engineer Scr. No 15775/ 03 Headache Pulsating with photophobi a, nausea, vomiting and Vertigo Since 5 years	Classical Migraine		Father- Hypertensio n Mother- Bronchial Asthma	F.M.- Sycotic D.M.- Psora	MIND - ANGER - easily MIND - ANXIETY - health; about - own health; his MIND - BROODING MIND - COMPANY - aversion to MIND - INSECURITY; mental HEAD - PAIN - Forehead, in - extending to - occiput HEAD - PAIN - pressure, external - amel. HEAD - PAIN - pulsating HEAD - PAIN - summer HEAD - PAIN - sun, from exposure to EYE - PHOTOPHOBIA STOMACH - APPETITE - diminished STOMACH - NAUSEA - headache, during GENERALS - FOOD and DRINKS - salt – desire	Nat.mur 200	7
20.	Mrs.S Age-34 Sex- Female Housewife Hindu Scr.no 15136/ 04 Headache Leftsided Pulsating with eye pain nausea and vomiting Since 1 year	Common Migraine	Backache		F.M.- Psora D.M.- Psora	MIND - ANGER - easily MIND - ANXIETY - health; about - own health; his MIND - COMPANY - desire for MIND - IRRITABILITY - headache, during HEAD - PAIN - morning HEAD - PAIN - pulsating HEAD - PAIN - Sides - left HEAD - PAIN - sleep - amel. STOMACH - NAUSEA - headache, during STOOL - HARD GENERALS - FOOD and DRINKS - meat - aversion GENERALS - FOOD and DRINKS - vegetables - desire	Nux.Vom 200	6

21.	Mrs.R Age-43 Sex- Female Housewife Christian Scr.No 18388/ 03 Headpain Throbbing With nausea Vomiting Vertigo and weakness since 19 years	Common Migraine			F.M.- Psora D.M.- Psora	MIND - BROODING MIND - COMPANY - aversion to MIND - SHRIEKING - anger, in HEAD - PAIN - mental exertion - from HEAD - PAIN - pulsating HEAD - PAIN - Sides - left HEAD - PAIN - sun, from exposure to STOMACH - NAUSEA - headache, during GENERALS - FOOD and DRINKS - chicken - desire GENERALS - FOOD and DRINKS - fish - desire GENERALS - FOOD and DRINKS - vegetables - desire GENERALS - FOOD and DRINKS - warm drinks – desire	Nat.Mur 200 Spig 30	5
22.	Mrs.G Age-34 Sex- Female Housewife Christian SCR.NO- 15354/ 03 Headpain Temples, Leftsided With blurring of vision, nausea and giddiness Since 15 Years	Common Migraine	Leucorrho ea	Mother- Diabetes Mellitus Hypertensio n	F.M.- Sycotic D.M.- Psora	MIND - ANGER - easily MIND - BROODING HEAD - PAIN - pressure, external - amel. HEAD - PAIN - pulsating HEAD - PAIN - Sides - one side HEAD - PAIN - sun, from exposure to FEMALE GENITALIA/SEX - LEUKORRHEA - menses - before FEMALE GENITALIA/SEX - LEUKORRHEA - white FEMALE GENITALIA/SEX - MENSES - late, too GENERALS - FOOD and DRINKS - fish - desire GENERALS - FOOD and DRINKS - meat - aversion GENERALS - FOOD and DRINKS - milk - aversion GENERALS - FOOD and DRINKS - sweets – desire	Nat.Mur 200 1m	7

23.	Mrs.O Age-27 Sex- Female Housewife Christian Scr.no- 14939/ 03 Headpain Onesided Frontal with blurred vision Colours in front of eyes, nausea Since 5 years	Classical Migraine	Bronchial Asthma, Sneezing, Eructation s		F.M.- Sycotic D.M.- Sycotic	MIND AILMENTS anger from MIND FEAR disease of impending MIND FEAR snakes HEAD PAIN FOREHEAD in hammering in HEAD PAIN sun from exposure to HEAD PAIN vomiting amel. VISION BLURRED headache before NOSE SMELL diminished NOSE SNEEZING dust causes STOMACH APPETITE diminished STOMACH thirstless STOOL hard RESPIRATION DIFFICULT cough with RESPIRATION DIFFICULT night GENERALS FOOD & DRINKS sweets aversion	Lyco 200	7
24.	Ms.P Age-15 Sex- Female Hindu Student Scr.No 21759/ 04 Head pain frontal One sided With blurring of vision weakness Since 1 year	Classical Migraine	Menstrual complaint s	Father- Diabetes Mellitus	F.M.- Sycotic D.M.- Psora	MIND ANXIETY; Anticipation from, engagement an MIND FEAR; High places of MIND; LAZINESS MIND; MILDNESS MIND SENSITIVE MIND WEEPING HEAD PAIN FOREHEAD IN pulsating VISION BLURRED Headache before FACE perspiration STOMACH THIRST large quantities for FEMALE GENETALIA/SEX - LEUKORRHEA - menses - before FEMALE GENETALIA/SEX- MENSES late too GENERALS FOOD & DRINKS Cold drink, cold water desire GENERALS FOOD& DRINKS sweets desire GENERALS FOOD& DRINKS Vegetables aversion	Nat.mur 1m	7
25.	Ms.S Age-17 Sex- Female Student Hindu Scr.No- 12760/ 03 Head pain one-sided Pulsating, Numbness of head weak memory Since 2 years	Classical migraine	Burning pain abdomen	Mother- Hypertensio n	F.M.- Sycotic D.M.- Psora	MIND - BROODING MIND - MEMORY - weakness of memory MIND - WEEPING - amel. HEAD - NUMBNESS; sensation of - Forehead HEAD - PAIN - Forehead, in - noise HEAD - PAIN - Forehead, in - pressure - amel. HEAD - PAIN - Forehead, in - pulsating HEAD - PAIN - Forehead, in - reading, while HEAD - PAIN - sun, from exposure to STOMACH - THIRST - cold water GENERALS - FOOD and DRINKS - ice cream - desire GENERALS - REST - amel.	Nat.Mur 1m	6

26.	Sr.D Age-36 Sex- Female Teacher Christian Scr.No 16947/ 03 C/O Headpain Left sided Nausea Weakness Since 5 years	Common Migraine	Leucorrho ea	Father- Hypertensio n Past History- Haemo rrhoids	F.M.- Sycotic D.M.- sycotic	MIND - AILMENTS FROM - anger - suppressed MIND - FASTIDIOUS MIND - SYMPATHETIC HEAD - PAIN - Forehead, in - extending to - occiput HEAD - PAIN - menses - before HEAD - PAIN - pressure, external - amel. HEAD - PAIN - Sides - left MOUTH - DISCOLORATION - Tongue - white RECTUM - CONSTIPATION RECTUM - ITCHING STOOL - HARD FEMALE GENITALIA/SEX - LEUKORRHEA - menses - before PERSPIRATION - PROFUSE GENERALS - FOOD and DRINKS - sour food, acids – aversion	Sepia 200 Nux.Vom 200	7
27.	Mrs.T Age-40 Sex- Female Nursing Christian Scr.No- 19468/ 04 C/O – Headpain Onesided Throbbing With giddiness Nausea and Blurring of Vision since 13 years	Common Migraine	Eructation s	Father- Bronchial Asthma Mother- Bronchial Asthma Diabetes Mellitus	F.M.- Sycotic D.M.- Psora	MIND - COMPANY - desire for MIND - CONTRADICTION - agg. MIND - IRRITABILITY - headache, during MIND - SHRIEKING - anger, in VERTIGO - HEADACHE - during HEAD - PAIN - morning HEAD - PAIN - Sides - left HEAD - PAIN - Sides - one side VISION - DIM - headache - during STOMACH - ERUCTATIONS - amel. STOMACH - NAUSEA - headache, during FEMALE GENITALIA/SEX - MENSES - copious PERSPIRATION - PROFUSE GENERALS - FOOD and DRINKS - pickles - desire GENERALS - FOOD and DRINKS - sweets – desire	Kali carb 200	7
28.	Mrs.S Age-30 Sex- Female Housewife Hindu Scr.No 19493/ 03 C/O Headpain Left sided with nausea Vomiting and blurring of vision Since 3	Common Migraine			F.M.- Psora D.M.- Psora	MIND - ANXIETY - anticipation; from MIND - COMPANY - aversion to MIND - IRRITABILITY - consolation - agg. MIND - SHRIEKING - anger, in HEAD - PAIN - menses - before HEAD - PAIN - Sides - left HEAD - PAIN - Sides - one side HEAD - PAIN - sun, from exposure to VISION - DIM - headache - during STOMACH - NAUSEA - headache, during FEMALE GENITALIA/SEX - LEUKORRHEA - menses - after FEMALE GENITALIA/SEX - MENSES - copious PERSPIRATION - ODOR - offensive PERSPIRATION - PROFUSE	Nat.Mur 1m	6

	years					SKIN - DRY - burning GENERALS - FOOD and DRINKS - cold drink, cold water - desire GENERALS - FOOD and DRINKS - fat – desire		
29.	Mrs.G Age-29 Sex-Female Housewife Hindu Scr.No 23748/ 04 C/O Headpain Nausea vomiting Weakness Since 1 year	Common Migraine		Mother-Migraine	F.M.-Psora D.M.-Psora	MIND - ANXIETY - health; about - own health; his MIND - FEAR - failure, of MIND - FASTIDIOUS PERSPIRATION - SCANTY sweat MIND - INDUSTRIOUS, mania for work STOMACH - APPETITE - diminished HEAD - PAIN - pulsating HEAD - PAIN - sleep - amel. HEAD - PAIN - pressure, external - amel. STOMACH - NAUSEA - headache, during HEAD - PAIN - vomiting - amel. HEAD - PAIN - sun, from exposure to GENERALS - FOOD and DRINKS - fruit - desire GENERALS - FOOD and DRINKS - spices - aversion	Nat.Mur 200	7
30.	Mrs.D Age-29 Sex-Female Housewife Hindu Scr.No 15498/ 03 C/O Headpain Left sided Pulsating Weakness Loss of taste Nausea Since 7 years	Common Migraine	Cramping Pain In Extremities	Mother-Hypertension Sister-Migraine	F.M.-Sycotic D.M.-Psora	MIND - ANXIETY - health; about - own health; his MIND - BROODING MIND - FEAR - crowd, in a MIND - IRRITABILITY - headache, during HEAD - PAIN - pressure, external - amel. HEAD - PAIN - pulsating HEAD - PAIN - Sides - left HEAD - PAIN - summer HEAD - PAIN - sun, from exposure to STOMACH - THIRSTLESS EXTREMITIES - PAIN - cramping EXTREMITIES - PAIN - pressure - amel. GENERALS - FOOD and DRINKS - fish - desire GENERALS - FOOD and DRINKS - meat - desire GENERALS - WEAKNESS - headache – during	Nat.Mur 200	6