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Could Migrain be A Part of History?

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As what is called migrain hasn't any definitive aetiology [almost diagnosed by exclusion], I tried to have an explanation of that mesterious headache on the light of the basic medical sciences {anatomy. physiology. pathology .microbiology} concluding that it is just a case of nasal sinusitis –definitely **sphenoidal sinusitis.** There for I managed these cases successfully as sinusitis resulting in improving of almost all cases within about one week. All these cases were previously diagnosed and treated as migrain by neurologists for long periods. First: Anatomical facts about Sphenoidalsinus: [It has a very variable anatomy].

1. It's size varies from 0.5 to 30 ml.

2.It has relations with many important structures: (a): the Internal carotid artery posterior-laterally where the bony wall in between may be absent. (b): the Optic canal posterior-laterally where the separating bony wall may present dehiscences also. (c): the sellaturcica containing the pituitary gland in the roof of the sinus posteriorly. (d):the maxillary nerve and nerve of the pterygoid canal inferiorly. (e): the pterygopalatin fossa lies anterior to the base of the greater and the lesser wings of pterygiod bone where the sphenoid air cells may extend to.

3.the pterygopalatine ganglion gives nerve supply to the sphenoidal sinus.

(1)Second: The physiological nasal cycle: where there is alternative blockage of both sides of nose which is normally unnoticed, but it may be exaggerated and annoying some people to the extent that they ask medical advice.

(2) Third: The pathological ciliary dyskinesia: either primary (Kartagener's syndrome) (3) or secondary (due to viral or bacterial infections, smoking, allergy. etc.) (4) Resulting in stagnation of mucus that invites infection and irritation of goblet cells of the mucous membrane so production of more thick mucus and so on.

Now: We can expect what would happen if there is an inflammation within this sinus. So, let's think about the sequence of events that may explain the symptoms of what is called (migraine).

Let's say: A person having either primary or secondary muco-ciliary abnormality and an anatomical abnormality meanwhile with the triggering exaggerated nasal cycle that leads to blockage of the sinus ostium. The air within the sinus cavity will soon be absorbed creating a negative pressure that pulls on the mucous membrane which may be adherent to the dura covering of optic nerve within the optic canal

causing the visual component of the (aura): light flashes and blind spots. Lickly, irritation of the maxillary nerve. the nerve of pterygoid canal orpterygopalatin ganglion may lead to a variety of cephalgias and cranial autonomic symptoms. Later on mucus accumulates and being infected leads to the severe throbbing headache which is correlating with the carotid pulsations. Generaly speaking, all the manifestations of migrain can be attributed to sinusitis. Accordingly, I treated these cases successfully by: (1) levofloxacin for 7 days. (2) nasal degongestant. (3) mucolytic. (4) piroxicam.

But there is an important question. that is why Otorhinolarygologists haven't noticed that relation between sinusitis and migrainous headache ?The answer is that they treated that cases with the improper antibacterial drugs (cephalosporins and other betalactam antibiotics) which are ineffective in treating multimicrobial environment where anaerobic organisms coexist with gram –ve in a synergesting relationship. SO, giving the proper antibiotics against both of them at the same time is essential to control that situation. Lastly, this is myopenion which needs scientific varification.

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