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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

Migraine in childhood

SIR,—The frequency of childhood migraine is poorly appreciated in many paediatric textbooks, so we the undersigned, who are concerned at the lack of understanding of migraine in children, have been discussing the topic at two meetings organised by the British Migraine Association. We would like to draw the attention of our colleagues to our conclusions and open the subject to discussion.

In 1962 the Ad Hoc Committee on Classification of Headache[1] defined migraine as "Recurrent attacks of headache, widely varied in intensity, frequency and duration. The attacks are commonly unilateral in onset; are usually associated with anorexia and, sometimes, with nausea and vomiting; in some are preceded by, or associated with, conspicuous sensory, motor and mood disturbances; and are often familial." This definition is widely accepted. It is, however, founded on presentations of migraine in adults, and does not cover certain aspects of the condition as it presents in children.

We found migraine in childhood difficult to define. It may present from early infancy on, and under the age of 10 has an equal sex incidence. All known types occur, classical and common migraine being the most frequent presentations. Migraine of so-called basilar, hemiplegic, and ophthalmoplegic type can also be recognised from infancy onwards.

Typically, migraine attacks in childhood have an acute onset with headache, commonly frontal, accompanied by some of the following features: nausea with or without vomiting, anorexia, malaise, pallor, and a desire to sleep. Less commonly there may be eye pain, profound lethargy with or without hypotonia, sensory (commonly visual), motor, or mood disturbance, ketosis, and pyrexia. Attacks are usually over within 24 h, but episodes may cluster. In some children headache may be insignificant and the systemic upset predominant; such cases are not always readily diagnosed or accepted as migraine.

There are various symptom complexes which may be associated with migraine in childhood, although the validity of the relationship is not clearly established. These include: (*a*) Recurrent abdominal pain—colicky or epigastric aching; the pain is short-lived and central and may be accompanied by abdominal distension, nausea, and vomiting; the vomiting may be biliary, and lead to ketosis and dehydration (cyclical vomiting). (*b*) Episodic malaise, with anorexia, pallor, fever, and pale stools.

Our studies of this subject are continuing and we would appreciate observations.

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[1] Friedman, A P, *et al*, *Archives of Neurology*, 1962, **6**, 73.

Routine procedures in general anaesthesia

SIR,—I am grateful to those who have commented on my Personal View (22 April, p 1049) both through your columns and in personal letters: in the latter case I am particularly grateful for the kind comments that have been made.

Dr M A Thompson's pleasantly temperate letter (13 May, p 1275) suggests that my communication illustrates the changes between anaesthesia as it used to be and as it is now, which may well be the case. This change, if I interpret his letter correctly, is exemplified by the increased use of relaxants and of the endotracheal tube in cases in which the latter is not necessarily essential to the maintenance of a good airway. Up to the time of my