Bölüm 5

MİGREN VE TEDAVİ YAKLAŞIMI

Mesude TÜTÜNCÜ[1]

GİRİŞ

Migren, baş ağrısı atakları, geri dönüşlü nörolojik ve sistemik bulgularla karakterize kronik nörolojik bir hastalıktır. Migrenin bir yıllık prevelansı genel popülasyonda %12, yaşam boyu prevalansı kadınlarda %33 ve erkelerde %12'dir (Lipton, 2007a, 2011). Migren erişkin dönemde kadınlarda belirgin derecede fazla görülmesine rağmen, prepubertal dönemde migren başlangıç oranı erkeklerde daha fazladır (Lipton 2007b, Bille 1997). Üçüncü ve beşinci dekat arasında sık gözlenirken orta yaştan sonra kısmi olarak daha az gözlenir. Migren hastaları arasında % 20'si iki veya üç gün süren atak geçirir. % 1 hastada en az 1 gün migren baş ağrısı çekmektedir (Stewart 1996). Dünya sağlık örgütü verilerine göre migren dünyada üçüncü en sık sağlık problemi olup, ikinci en sık özürlülük verici nörolojik bozukluktur.

MİGRENİN KLİNİK PRESZENTASYONU

Migren izole bir baş ağrısı olarak düşünülmemektedir. Baş ağrısı duysal ve bedensel semptomlara eşlik eden bir semptomdur. Migren atağı 4 evreden oluşmaktadır, premonitory evre, aura evresi, baş ağrısı evresi ve postdromal evre. Premonitory evre, ağrı başlangıcından veya auradan saatler hatta günler önce başlayabilir (Gin 2003). Premonitory evrede gözlenen başlıca semptomlar çok değişken olmakla beraber başlıcaları; yorgunluk, konsantrasyon güçlüğü ve boyun sertliğidir.

Baş ağrısı pik süreleri kısa olan hasta gurubunda etkin ve hızlı tedavi yapabilmek için bu semptomaları tanımak oldukça önemlidir.

Migren hastalarının yaklaşık üçte birinde aura adı verilen ağrı başlamadan önce ortaya çıkan geri dönüşlü nörolojik bozukluklar vardır. En yaygın aura, auralı hastaların % 90'ından fazlasında ortaya çıkan görsel auradır. En yaygın gözlenen görsel auralar skotom, şimşek benzeri lezyonlar ve teikopsidir (Rus-

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