Late-life migrainous accompaniments are benign episodes of acephalgic migraine symptoms, most often migraine aura. They may occur for the first time after the age of 45, sometimes in persons with no history or a distant history of migraine or headache. The spells last from 15 minutes to 60 minutes. Typical symptoms are visual and include scintillations, fortification spectra, photopsia, scotoma, and hemianopsia. Other symptoms include numbness, motor weakness, aphasia, and dysarthria. The International Headache Society (IHS) has recognized this condition and classified it as “migraine aura without headache” in its diagnostic criteria.

A study evaluating the Framingham cohort found that migrainous accompaniments were not as rare as originally thought. Visual migrainous symptoms were reported by 1.23% of the cohort but only 65% of the episodes could be stereotyped. In fact, only 19% met the IHS criteria. When the spells are stereotypical and have occurred several times, diagnosis is usually straightforward. However, in those individuals without a migraine history who have had only 1 spell, other conditions such as transient ischemic attacks or seizures are usually considered first, thus complicating diagnosis.

Treating late-life migrainous accompaniments also has challenges because of the age of the patient population (ie, drug tolerability and preexisting cardiac disease), and many of those patients are already taking multiple medications for other medical problems.

This small, ongoing study evaluated the efficacy and safety of topiramate as a prophylactic therapy for late-life migrainous accompaniments. Topiramate has already shown benefit in migraine prophylaxis in small studies, and it has a favorable cardiac safety profile, making it an attractive agent for this disorder. Eight patients over the age of 65 were given topiramate beginning at 15 mg/day, increasing up to 100 mg bid. Their duration of attacks at baseline was 15 minutes to 1 hour, with 5 to 14 episodes per week. Four of the patients had a previous history of migraine with aura, and transient ischemia was excluded in all patients before topiramate was given.

The results show that the time to aura-free status was 3 weeks to 12 weeks. Four of the eight patients were aura-free in 3 weeks to 5 weeks. None of the patients discontinued due to adverse events, which were typical with topiramate use (weight loss, paresthesias, dry mouth, and dizziness). Two patients dis- continued therapy for 1 week to 2 weeks due to a pacemaker implantation and reanastomosis of the colon. Both patients voluntarily resumed topiramate therapy because their auras later returned. These results suggest that topiramate may be an effective therapy for late-life migrainous accompaniments by modulating cortical hyperexcitability.

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REFERENCES