Ranitidine in Migraine

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Histamine is known to be a potent dilator of contracted extracranial arteries [5], and it has recently been shown to cause an increase in the permeability of cerebral blood vessels to sucrose [2]. This effect is blocked by H2 antagonists [2], and Pawlik et al [3] have shown that the longer-phase component of the vasodilatation induced by histamine in the dog mesenteric bed is blocked by H2 antagonists alone. Despite this effect, cimetidine and chlorpheniramine, both separately and together, have no prophylactic value in migraine [1]. The newer H2 antagonist ranitidine, at a dose of 80 mg, produces 95% inhibition of gastric acid secretion compared to the 66% inhibition achieved with 400 mg of cimetidine [4], the dose used by Anthony et al [1]. Total blockade requires 800 mg of cimetidine [7]. We therefore assessed ranitidine as a treatment for migraine.

Eight women and two men fulfilling Vahlquist's criteria for migraine [6] were given 150 mg of ranitidine three times a day for three months in an open study. They had a mean of 3.25 attacks in the month before the study, and 3.10 in the third trial month. A paired t test showed no significant change ($t = 0.345, p > 0.05$). One patient considered herself slightly improved and one worse; the rest were subjectively unchanged.

This study suggests that the ineffectiveness of cimetidine in migraine is not due to its limitations as an H2 blocker in acceptable doses, and that histamine, at least extracellularly, has no role in the pathogenesis of migraine.

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Urinary Retention as a Sole Symptom of Intracranial Calcified Mass at the Rolandic Fissure

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Urinary retention associated with an intracranial lesion is rare. We report such an association in a patient with a small lesion at the right rolandic fissure, confirmed by radiological studies and craniotomy.

The patient was a 39-year-old right-handed woman, admitted in April, 1980, with the sole complaint of intermittent difficulty passing urine, which sometimes necessitated catheterization. On such occasions she could not void urine despite straining and a painful and strong urgency. Urinary catheterization immediately relieved her symptoms. During the six months prior to admission, episodes of such retention occurred from one to three times a week. Physical examination on admission revealed localized tenderness to percussion at the right parietal area of the skull. A rectal examination showed full voluntary control of the external sphincter of the anus. Neurological examination disclosed no abnormality except for bilateral hyperreflexia.

No abnormality was detected on lumbosacral roentgenograms, intravenous pyelography, urinalysis, cystoscopy, and cystometry. Skull roentgenograms and cranial computerized tomography showed a sharply marginated calcified mass located at the right superior convexity (Figure). By July she had developed a minimal left hemiparesis and began to experience sensory seizures involving the left side of her body. At craniotomy an osteoma 1 cm in diameter was found attached to the dura mater and slightly depressing the underlying sensorimotor cortex; it had buried itself in the uppermost portion of the right rolandic fissure. Postoperatively she has had no difficulty voiding, and the hemiparesis has disappeared.

It is well documented that frontal tumors give rise to urinary incontinence [1, 3], but few reports indicate that frontal lesions can result in urinary retention [1, 4, 5]. Andrew and Nathan [1] described two patients who developed urinary retention after brain surgery. The medial half of the left frontal lobe was removed in one, the anterior half to two-thirds of the right frontal lobe in the other. They also reported urinary retention accompanying an intracranial hematoma located on the medial side of the right frontal lobe [1]. In their patients, retention of urine was not associated with any sense of urinary urgency [1]. Pool [4] described the occurrence of urinary retention following bilateral cortical ablation of Brodmann's areas 8 and 9. He also reported a case of right frontal convexity meningioma associated with difficulty initiating micturition [5]. Czyhlarz and Marburg [2] observed urinary retention,

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