https://doi.org/10.1590/0004-282X20200123

One more bite in the understanding of migraine psychiatric comorbidity: the role of eating attitudes

Uma porção a mais no entendimento das comorbidades psiquiátricas em migrânea: o papel do comportamento alimentar

Mario Fernando Prieto PERES[1]

[1]Universidade de São Paulo, Faculdade de Medicina, Instituto de Psiquiatria, Hospital das Clínicas, São Paulo SP, Brazil.

Mario Fernando Prieto PERES https://orcid.org/0000-0002-0068-1905

Correspondence: Mario Fernando Prieto Peres; E-mail: marioperes@usp.br

Conflict of interest: There is no conflict of interest to declare.

Received on August 10, 2020;
Received in its final form on August 10, 2020;
Accepted on August 10, 2020.

Hamanci et al.[1] studied 91 episodic migraine patients and 84 non-headache, non-pain controls detailing psychiatric comorbidity, impact, and quality of life scales. Eating behavior was investigated by the Eating Attitude Test (EAT), added to the usual anxiety-depression and personality axis evaluations[2]. A score equal to or higher than 30 on EAT was found in 23% of migraine patients, 2.4 times more frequent in migraine subjects than in controls. EAT scores were higher in migraine *vs.* controls. Associations between migraine and eating disorders were related to headache severity, depression, anxiety, quality of life, neuroticism personality traits, and less education.

What is yet to be determined is whether dysfunctional eating attitudes are cause, consequence, or even originated from other mechanisms such as genetics, culture, or lifestyle, thus influencing both migraine and psychiatric comorbidities. A cross-sectional design would not provide enough data to reply to those questions, such as a longitudinal study could[3].

Eating behavior evaluation should be part of headache care. It has many clinical implications, is part of human existence, and is a critical feature in aspects well-linked to headache management such as obesity, metabolic disorders, migraine triggers, and psychiatric comorbidities.

Abnormal eating habits may reflect a wide range of psychiatric issues, including the comorbidity of eating disorders (binge eating, anorexia nervosa), decreased or increased eating secondary to depression, anxiety, and obsessive-compulsive behavior[4]. Social pressure and weight stigma may be additional factors for stress in migraine patients. The EAT scale is a 26-item questionnaire covering those features. Additional components of eating habits, however, are also important to be ascertained in headache patients, such as the quality, amount, and schedule of food intake and food craving as a migraine prodrome.

Fasting is one of the main triggers mentioned in migraine journals. Abnormal intake of certain foods or ingredients may also cause more headache episodes, such as caffeine, lactose, sugar or sweeteners, citric fruits, gluten, nuts, salt, alcohol, meat, sausages, and ice cream[5]. The cause-effect relationship, however, is not clearly established. Patients may not be aware of food triggers, or the dietary item may not be consistent as a causative agent. One may also address meals schedule so hypoglycemia is ruled out as a precipitating factor[6]. In addition, craving for certain foods, such as sweets, chocolate, and carbohydrates, may be part of a migraine prodrome. Identifying this symptom may help prevent an upcoming migraine episode. Although considered to be a hypothalamic driven event, through orexinergic pathways[7], excessive intake of chocolate or other caloric foods can be confounded as a migraine trigger. Since these items are known to have anxiolytic effects, a plausible explanation is that anxiety comes first, caloric food is ingested in order to overcome it, and headaches emerge due to the high anxiety levels and not necessarily to the type of food intake. Let us take a deeper look into eating habits in headache management.

References

1. Hamamci M, Karasalan Ö, İnan LE. Can personality traits, obesity, depression, anxiety, and quality of life explain the association between migraine and disordered eating attitudes? Arq Neuro-Psiquiatr. 2020. Epub Aug 21, 2020. http://dx.doi.org/10.1590/0004-282x20200046
2. Peres MFP, Valença MM, Silva-Neto RP. Management of psychiatric comorbidities in migraine. Headache Medicine. 2018;9(2):61-67.
3. Xu J, Kong F, Buse DC. Predictors of episodic migraine transformation to chronic migraine: A systematic review and meta-analysis of observational cohort studies. Cephalalgia. 2020 Apr;40(5):503-16. https://doi.org/ 10.1177/0333102419883355
4. Peres MFP, Mercante JPP, Tobo PR, Kamei H, Bigal ME. Anxiety and depression symptoms and migraine: a symptom-based approach research. J Headache Pain. 2017 Mar;18(1):37. https://doi.org/10.1186/s10194-017-0742-1
5. Kraya T, Schulz-Ehlbeck M, Burow P, Watzke S, Zierz S. Prevalence and characteristics of headache attributed to ingestion or inhalation of a cold stimulus (HICS): A cross-sectional study. Cephalalgia. 2020 Mar;40(3):299-306. https://doi.org/10.1177/0333102419884938
6. Silva-Néto RP, Soares AA, Peres MF. Hypnic headache due to hypoglycemia: a case report. Headache. 2019 Sep;59(8):1370-3. https://doi.org/10.1111/head.13627
7. May A, Burstein R. Hypothalamic regulation of headache and migraine. Cephalalgia. 2019 Nov;39(13):1710-9. https://doi.org/10.1177/0333102419867280