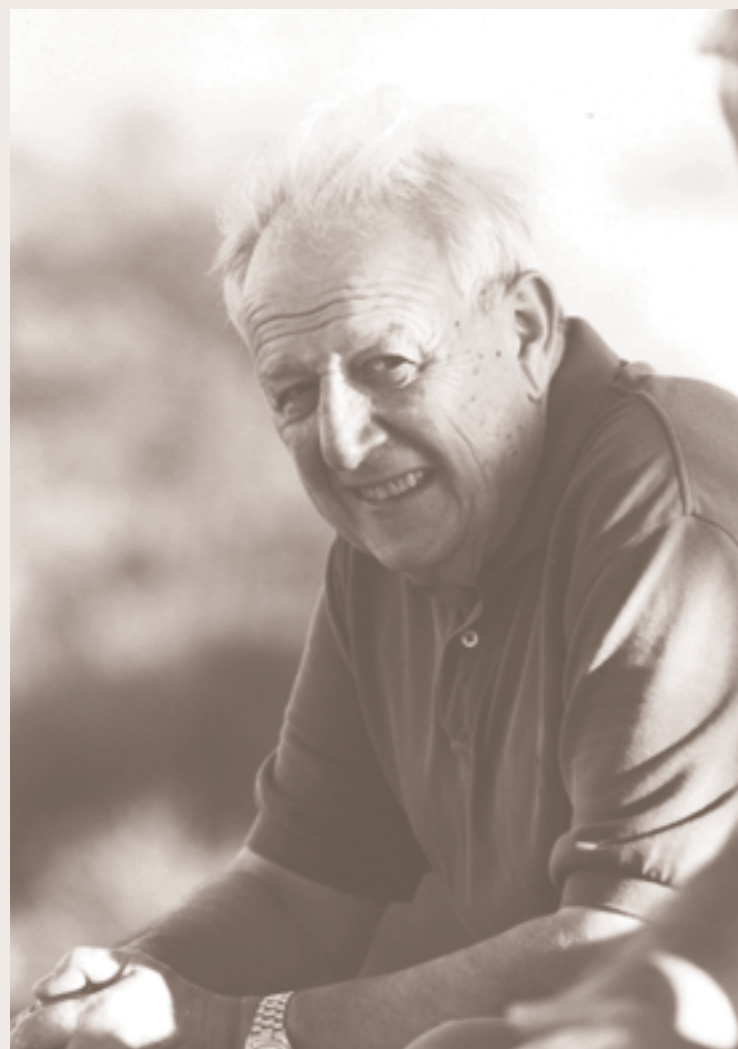


The Man Who Put “Headache” on the Medical Map

AN INTERVIEW WITH SEYMOUR DIAMOND, MD

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DR. DIAMOND is the founder and director of the Diamond Headache Clinic and the Diamond Headache Inpatient Unit, Saint Joseph Hospital, Chicago, Illinois. He is Adjunct Professor of Cellular and Molecular Pharmacology and Clinical Professor of Family Medicine at the Chicago Medical School at Rosalind Franklin University of Medicine and Science, North Chicago, Illinois. Dr. Diamond has served as editor for 16 publications and currently serves as Editor-in-Chief of the journal *Headache and Pain-Diagnostic Challenges, Current Therapy*. He has published over 450 articles and authored and coauthored over 63 books. Dr. Diamond serves as the Executive Chairperson of the National Headache Foundation.

My father tried things that nobody else would even touch. — Merle Diamond, MD

Q. Dr. Diamond, your work launched a new field of medicine and established “headache” as a true disorder. At what point in your medical career did you recognize that headaches needed more attention than they were being given? What did you see that no one else had seen before?

DR. DIAMOND. I did some original work in the late fifties and early sixties on the tricyclic antidepressants. These were the second group of recognized antidepressants. The first were the MAOIs [monoamine oxidase inhibitors]. I noticed that when patients with depression used these medicines, their physical complaints lessened along with their depression. I then started prescribing these drugs for people who were not *obviously* depressed, and I discovered that their physical complaints were also getting better.

I correlated these findings into what I called a hidden or ‘masked’ depression. In 1963, I did an exhibit (there weren’t poster sessions at that time) and won a gold medal at the national AMA convention (that’s when the AMA wasn’t just a political organization, it held large educational conventions). The exhibit was called ‘Masks of Depression.’ While I showed at this exhibit, various psychiatrists and physicians came by and they laughed at this concept. At the time, the whole field of psychiatry, and the whole interpretation by physicians (and I’m talking about the nonpsychiatric society), was based on ‘talking’ as a way to solve problems. So among the Freudian, Adlerian, and Jungian psychologists—and the whole culture—it was inconceivable that antidepressants could help people at all, which was fascinating. At that time (and I changed my mind a few years later), I also believed that all these people I was talking about (with these somatic complaints) had a hidden depression. I’ve learned since that time that the tricyclic antidepressants and

the MAOIs, *not* the SSRIs [selective Serotonin Reuptake Inhibitors], probably have a unique quality that helps somatic complaints—not exclusive of their antidepressant qualities.

Q. Was there a particular turning point in your work?

DR. DIAMOND. Yes, at the same time as this exhibit at the AMA convention, an internist named Lester Blumenthal asked me about the relationship between headache and depression. He had a particular interest in headache. I went back to my busy practice and observed my headache patients using the tricyclic antidepressants.

In 1964, I presented my findings at a meeting of the American Association of the Study of Headache, in San Francisco. The organization is now known as the American Headache Society. At that time, it was a small organization. There were only 16 people at the meeting, which ran at the same time as the annual AMA meeting. A very prominent internist from the Mayo Clinic, Dr. Bayard Horton, and the head of the Department of Internal Medicine at the Cleveland Clinic, Dr. Leonard Loveshin, noted my interest in headache—and I guess were impressed with my work—and encouraged me to run for the office of Executive Secretary in 1965. I served as the Executive Secretary from 1965 to 1971. In 1971, they created a new position, which they called Executive Director, and I served in that position until 1985. Additionally, from 1972 to 1974, I was the president of the organization.

Q. So you became a headache specialist?

DR. DIAMOND. [Laugh] Yup.

Q. In 1972, you opened the Diamond Headache Clinic. What led to that decision?

DR. DIAMOND. The clinic was a general practice, but I was already leaning toward seeing headache patients. In 1972, I decided to make the break and it became a headache clinic. At that time, chronic headache was a very mistreated and misdiagnosed disease.

Q. Were there any other headache clinics at the time, or was yours the first? If so, what was different about the Diamond Headache Clinic?

DR. DIAMOND. There were a few others, but they were affiliated with a medical school, a hospital, or some type of institution. There are some things, however, that distinguished our clinic. For example, in those other clinics a treatment would be recommended, but there was no continuity of care. At our clinic, we coordinated care of patients. And even today, the major thing that is different about our clinic—and it’s something I still stress when I give my lectures—is that the headache patient needs continuity of care.

Today we’re at a stage where we can control or alleviate most headaches.

Q. In terms of assessment and diagnosis, was there anything different about what you did at your clinic?

DR. DIAMOND. Yes. I established an in-depth headache history for each patient. We would delve deeply into the patient's background and ask questions about such things as the location, severity, precipitating factors, and so on. And we also asked about environmental factors that might have influenced the headaches. We spent a lot a time with patients, which others were not doing.

Here is an example. People would come to us and say they were experiencing headaches on weekends. We call these "weekend headaches." When we questioned these patients, we would find out that they were oversleeping on the weekend. I would tell them to get up at the same time as they did on weekdays, have something to eat, and go back to bed. When they did that, they didn't get weekend headaches. Another example of a weekend headache: people would say that they drank four cups of coffee on a workday, but did not drink coffee on the weekend.

Q. They had caffeine withdrawal?

DR. DIAMOND. Yes.

Q. So taking time with patients was a critical factor that distinguished patient care at your clinic from other practices?

DR. DIAMOND. Yes. In addition to taking a detailed history, we did a follow-up with patients in which we went over their treatment plans very carefully. In other offices, these instructions were [chuckle] 'loosely' given. We took the time to talk to patients about what medications they were taking and why they were taking them.

In addition, later on we incorporated biofeedback, exercises, and other modalities that would help patients.

Q. What has changed in headache treatment since the opening of the clinic?

DR. DIAMOND. The biggest change came with the discovery of the triptan drugs, basically Imitrex. And the reason is that triptan drugs showed, for the first time, that you could reverse the headache process. At the time, Glaxo made a huge financial investment to launch a massive advertising campaign and educate physicians about this new treatment for headache. Then all of a sudden, neurologists and other physicians who treated headache opened clinics. Clinics blossomed everywhere. I would say that Glaxo got things started.

Q. When was that?

DR. DIAMOND. Imitrex was approved in 1993. It is interesting that it took twenty years in the laboratory to test the drug and get it approved.

Q. What has changed in understandings about the causes of headaches?

DR. DIAMOND. In about 1982, a Danish neurologist, Jes

Olesen, discovered that in classical migraine there was an electrical wave going over the cortex at 2 millimeters per minute. That was the first suggestion that migraine was not purely vascular; it also had neurological manifestations. And then later, the trigeminal nerve was implicated. This was the work of Michael Moskowitz at Harvard, and later on, Rami Burstein also at Harvard. All this implicates some neurological happenings with migraine along with the earlier vascular ones that were shown by Harold Wolff back in the fifties and sixties.

Q. Tell us more about what the clinic is like today.

DR. DIAMOND. First of all, we're the largest and oldest private headache clinic in the United States. We see about 2,000 new patients every year. About half the patients are referred by other patients who have done well. We also see 22,000 follow-up patients annually. But we not only have the outpatient clinic, we also have a satellite hospital unit—and it's the only acute headache treatment unit. People may be admitted to other hospitals for some headache treatment, but ours is a dedicated headache treatment unit with 38 beds.

Q. What kind of patients do you treat at the hospital unit? And who treats them?

DR. DIAMOND. We have people who are having severe episodes. They might have what is called 'status migraine'—migraine that lasts three or four days or several weeks; or they might have chronic cluster headache; and they might have been taking medicines improperly and become habituated or having rebound headache. We have an integrated treatment program for these people staffed by two dedicated psychologists and a psychiatrist, nurses who are knowledgeable about working with these patients, a pharmacist dedicated to this unit, and people who handle managed care. We have 5 biofeedback setups and physical therapy. And we have lectures for patients and their families. It's the only one of its kind in the United States. There's nothing else like it.

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Q. What's the usual stay in the unit?

DR. DIAMOND. The usual stay is five to eight days. After that, we either follow up with these patients at the clinic or we refer them back to their physicians once we've established the management program.

Q. What are the demographics?

DR. DIAMOND. About 70% of our patients are women. Only about 8 or 10% are over 65, in contrast to the typical hospitalized patient. In a typical hospital, you'd see about 55 to 60% in that group.

... triptan drugs showed, for the first time, that you could reverse the headache process.

Q. Do you see children?

DR. DIAMOND. Yes, we do. We will take children at any age, but most are over five.

Q. What are the most prevalent types of headache you see at the clinic?

DR. DIAMOND. Migraines are the most prevalent. Clusters are quite rare, but we do see a great number of resistant *chronic* clusters. Usually cluster headaches last for two or three months and go away, but we see a large population of patients with chronic clusters, and we see the mixed headache patient—this headache is called by various names (e.g., the transformed headache, chronic daily headache, transformed migraine).

Q. Do other clinics use your model?

DR. DIAMOND. [Laugh] Yes, everyone uses our model! But no one runs it as well as we do. They do it on an intermittent basis and there are several reasons for that.

I would love to run my clinic without being dependent on the insurance industry. People would have to pay their own bills, but it wouldn't be fair to do this to them.

When people call for an appointment, there are two dedicated, full-time people who try to help them work out their insurance problems and gain approval for admission to the clinic with whatever plan or financial arrangement they can manage. It's a shame that the situation is this way.

If patients have been examined and found to need further treatment in the hospital, we will help them. Most practices don't take the time to go through the managed care process to get prospective patients admitted. Once patients are admitted, there are still impediments to adequate treatment. Most insurance companies don't realize the seriousness of these patients' problems. They figure two days in the hospital are all that's necessary. We have the resources to make the insurance companies understand what's going on. All of this takes money. The average doctor who has a simple headache clinic cannot afford to do this, but we're big enough to do this.

Q. You also founded the National Migraine Foundation, which is now the National Headache Foundation. Tell us about the organization.

DR. DIAMOND. As I told you, my interest in headache evolved in the sixties, even though my clinic was formed in 1972. I visited Great Britain and presented a paper on headache in 1968 or '69, and at that time there was an organization called the British Migraine Trust that is still in existence. I visited their director and looked at their literature, and saw that the headache patient in the United States had a need for a society

as well. I organized that formally on June 9, 1970. The first newsletter went out in May 1972. There's now an executive director and a board. I'm still on the board and I have the title of Executive Chairman.

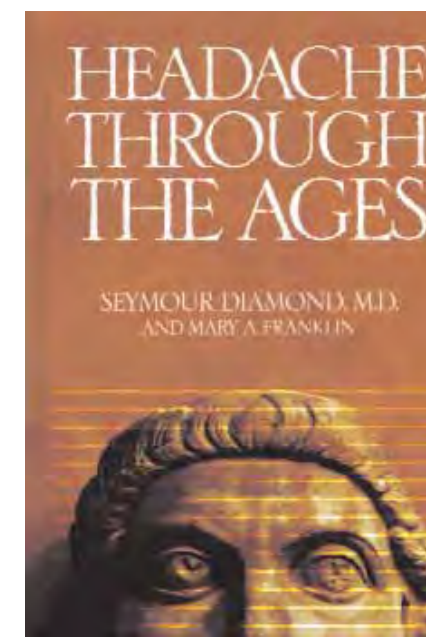
Q. Are you doing any research right now? If so, can you tell us about it?

DR. DIAMOND. Well, I'm doing some research on classical migraine with a type of magnet apparatus. We are very early in this process. The apparatus is a special cap that would be worn by somebody getting an aura, and it would possibly reverse the headache. Some of the nondrug treatments are fascinating. As you know, the fastest absorption of a drug occurs when the drug goes directly into the bloodstream from the lungs, and there are some new apparatuses that can facilitate that. There's also a lot of research being done on Botox, and we're researching it too. We're finding it helps with chronic daily headaches. We've also had a lot of success with biofeedback

Today we're at a stage where we can control or alleviate most headaches. I think that in the future we'll have better drugs that may abort or reverse migraine and treat the pain of headache more effectively. There will also be more efficient prophylactic or preventive medicines, and we'll have medicines with fewer side effects. There will be some new methods of administering medicines, so we can get the medicine into the body faster and more appropriately. And lastly, there may be some combination of drugs that will prove more helpful.

Headache Through the Ages

Q. You have a new book out called *Headache Through the Ages*, which was coedited by Mary A. Franklin. The book gives us an enlightening view of how headache has been viewed through time in art and literature, and includes anecdotal material about famous headache sufferers and



how they depicted their pain. What gave you the idea to write this book? How did you research it?
DR. DIAMOND. Mary, who has been on my staff since 1970, is interested in history. She's a big Civil War buff, and she told me a long time ago about Ulysses S. Grant and his headaches. This stimulated my interest in finding out about other

well-known people who got headaches. I just kept reading and taking down information. Eventually we accumulated enough information for an article, but we kept looking. It’s not a big book, but we decided that there was enough worthwhile information to interest people in reading it.

Q. What accounts by well-known authors, writers, poets, etc. did you find the most intriguing? Can you give us some examples?

DR. DIAMOND. Of course, I found all of the stories intriguing. I am fascinated by the stories about Ulysses S. Grant. ‘Stress relief’ acted as a remedy for his migraine. In a comment to his aide, Grant said, ‘The pain in my head seemed to leave me the moment I got Lee’s letter.’ This was, of course, Lee’s letter of surrender.

In the book we used a quote from a biography of Mary Queen of Scotland, also a migraineur: ‘... She was having one of her bad days—was sheer agony, so that for part of the way she tried to ease the blind pain by resting her head on her hand.’ You know she found a solution for her headaches.

Q. What’s that?

DR. DIAMOND. She got beheaded!

The story of Hildegard is also interesting. She was a brilliant, outspoken, and multifaceted woman who became the leader of her own Benedictine community in the 12th century. She was a reformer (at a time when women were ignored), a scholar, and an accomplished musician. In her illuminated manuscripts, she depicted her visions, which she believed were divinely inspired. What she may have been seeing were the bright lights and jagged lines associated with migraine aura.

Another story that is included in the book is about the eminent playwright George Bernard Shaw, who suffered excruciating headaches once a month until he was 70. One day after having an attack, Shaw had the chance to meet with Friedtjof Nansen, the Norwegian arctic explorer. Shaw asked the explorer if he had ever ‘discovered’ a cure for headaches. When Nansen replied, ‘No,’ Shaw countered, ‘Well, that is the most astonishing thing. You have spent your whole life in trying to discover the North Pole, which nobody on earth gives a tuppence about. And you have never attempted to discover a cure for the headache, which every living person is crying aloud for.’

Q. Do you see any connection between creativity and migraine? Or is it just that migraines are so prevalent in the population that some creative people are bound to have them?

DR. DIAMOND. This is not in the book, but I know the painter Helen Frankenthaler, who is a migraine sufferer. I once called her and asked if there was some connection between her painting and migraine. And she said, ‘No.’

But you can see this connection in the work of the painter De Chirico [1888-1978]. I refer to him often in my lectures. He was also a migraine sufferer with teichopsia (which means that he saw wavy lines). This was reflected in many of his paintings, especially in his horses. His sketches and paintings also indicate fortification spectra, such as in “The Return to the Castle,” a painting that depicts a knight nearing a fortress with spiky edges.

Your book concludes with the statement, ‘We can wonder why the headache is there, but we should also seek to end this terrible complaint.’ Perhaps no one has done as much as you, Dr. Diamond, toward this end.