Here are a few tips:

Wrapping up the face if going out in the cold or wind may help to prevent triggering neuralgia/migraines.

Stopping consumption of foods that trigger headaches can also be very helpful, if they can be identified: this can be achieved by elimination or rotation diets.

A food/symptom diary may help to elicit the problem foods. Generally, an elimination diet is carried out for 2 weeks and tends to consist solely of foods such as distilled water, lettuce, cauliflower, carrots, boiled or baked potatoes, cottage cheese, chicken, olive oil and distilled white vinegar.

Rotation diets are more complex.

Low blood sugar can be avoided by regular meals and eating low-sugar carbohydrates (e.g. bread, pasta) as these take longer to process and will give a more even blood sugar rather than a sudden rise which high sugar intake will cause.

Eating regular meals (which may be difficult if pain level impairs appetite) is essential in avoiding fluctuating blood sugar.

Avoid eyestrain if possible: limit computer time or use a screen overlay, which cuts down glare.

Carry a pair of sunglasses wherever you go and put them on if there is bright light (not necessarily sun: even on quite dull days, there can be a glare off wet roads).

Get your eyesight checked every 2 years

Attend a dentist at least once a year for a check-up.

Use menthol crystals or other preparations to reduce nasal stuffiness if you have a cold (to prevent sinusitis setting in): but avoid over-use of decongestant tablets or nasal sprays as you could get a rebound effect on stopping them.

Use **echinacea,** an herb, (in the short-term only) when you get a cold/'flu to help your immune system fight the illness and prevent chronic sinus trouble.

Avoid excessive alcohol intake.

Avoid prolonged physical stress/ strenuous exercise.

Avoid, if possible, undue emotional stress.

Fish-oil capsules have been studied in Cincinnati and it has been found that daily consumption may reduce the frequency of migraine attacks (60% of the study subjects reduced frequency from 2 a week to 2 a fortnight) as well as their severity.

Avoid using hormone treatment if you suffer from migraines

PROPHYLACTIC TREATMENT:

Aims to prevent attacks: If migraine symptoms respond to treatment but are very severe or occur more than twice per month, prophylaxis may be considered.

Preventive measures reduce the number and severity of attacks but do not cure migraine. They may effect only a 50% improvement.

They are usually taken daily for 6-8 months and then gradually stopped.

Propranolol: is the commonest and is the drug of choice. It is given at low dose, but may be increased if necessary.

It cannot be used in people with asthma, Raynaud's disease (poor circulation in hands and feet) or low blood pressure. It may reduce frequency, duration and intensity by around 40%. Side effects include lightheadedness, nausea, drowsiness, diarrhoea, insomnia, and depression.

Pizotifen: an alternative drug. It may cause sleepiness but this can be overcome by taking it at night. There may be weight gain.
However, it only slightly reduces frequency of attacks.

Amitriptyline: an antidepressant drug which some arachnoiditis patients may already be taking for pain relief. Other types of antidepressant (such as Prozac) are less effective.

Note that painkillers can still be taken should an attack occur.
(other drugs such as methysergide*, clonidine are not recommended in the guidelines)

Sodium valproate: an anticonvulsant drug may be of some help but is not licensed for this indication.

Anticonvulsant drugs such as gabapentin and topiramate have been evaluated for migraine prophylaxis in studies, which have suggested that around 30% efficacy, can be demonstrated.

This is worth noting primarily because gabapentin is a drug which is being used to treat the nerve-type pain associated with arachnoiditis: so that if you suffer both from migraines and arachnoiditis, this may be a drug worth bearing in mind.

For cluster headaches: a short course of prednisone may reduce an episode within a few days. Once the headaches are markedly reduced, the initial dose of 60-80mg every morning can be progressively reduced over a few weeks.

For chronic cluster headache, Verapamil (may need to be used at 800mg or more) and Lithium are used in the United States. Other treatments include anticonvulsants valproic acid and topiramate.

*Methysergide (an ergot drug) has been used 2mg three times a day but cannot be given for more than 6 months as it can cause serious adverse effects. (fibrosis in the abdominal cavity, lungs or heart valves) use of month long drug holidays inserted into prolonged treatment seems to have averted this rare complication.

ABORTIVE MEASURES:

Although generally I would suggest cutting out caffeine, (it can worsen some neurogenic pain) it can be very useful when a headache first starts: 1-2 strong cups as soon as the headache comes on may help. (If you are going to come off caffeine, be sure to do it very gradually as withdrawal can itself cause headaches).

Aspirin, paracetamol or NSAIDs (alone) are effective and should be started very early in the attack.

Migraine attacks are best treated as early as possible. Aspirin or Paracetamol, at full dose, are often effective. Full dose means 900mg aspirin (three tablets) or 1g paracetamol (two tablets). The dose can be repeated in 4 hours.

Soluble tablets work best as they are absorbed quickly.

Ibuprofen (brufen) or other 'anti-inflammatory' painkillers may be given as alternatives.

Anti-sickness medication given either as tablets or suppositories: metaclopromide or domperidone may help if nausea is a problem.

Again, they should be taken as early as possible in the attack.

Some migraine tablets combine a painkiller and an anti sickness medication. These may be useful but the dose of each constituent may not be strong enough or one or other of the constituents may not suit some people.

For cluster headaches: the most benign and frequently effective treatment is inhalation of oxygen through a mask using 100% oxygen at 8-10 litres a minute, for 10 minutes.

Ergotamine may be able to abort the attack in up to 75% of patients; given as a suppository or under the tongue to provide rapid onset of action. However, it has largely been superceded by Sumatriptan (Imitrex), which is generally given by injection and may be self-administered using an auto-injector to inject under the skin.

Alternatively, it may be given via nasal spray. A study of oral zolmitriptan published earlier this year reported that 10mg of the drug (a large dose) reduced pain considerably at 30 minutes in just under half the patients.