surgery is preferred when the patient does not respond to hormone therapy, lesions are extensive, or symptoms are severe.[8] In our patient, treatment with amitriptyline and several neuromodulators reduced symptoms only partially and caused adverse effects which limited the effectiveness of these drugs. Perineural injection of corticosteroids and anaesthetics improved symptoms temporarily, although pain returned with every new menstrual cycle. Our patient started hormone therapy while waiting to undergo decompression surgery; during that period, she became pregnant and remains completely asymptomatic to date.

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2173-5808/

'Chronic migraine' is a misnomer☆

Migraña crónica: una denominación poco adecuada

Dear Editor:

Chronic migraine has been addressed from many different perspectives given its high frequency and substantial degree of associated disability. Its diagnostic criteria have been revised according to the successive updates of the International Classification of Headache Disorders; the most recent version is the ICHD-3 beta.[1] These criteria enable accurate selection of patients for epidemiology studies, clinical trials, and for appropriate prescription of recently approved treatments, such as botulinum toxin type A.

Although there is consensus on the definition of chronic migraine (headache occurring on 15 or more days per month for more than 3 months, with features of migraine on at least 8 days per month), we feel that the Spanish term (*migraña crónica*) is misleading. The dictionary of the Royal Spanish Academy[2] defines *crónico* ('chronic') as an adjective describing a disease that is long-standing or habitual. We are positive that the term *migraña crónica* is a literal translation of the English 'chronic migraine'. In English-language dictionaries, 'chronic' is defined as lasting for a long period of time or marked by frequent recurrences.[3] This concept of recurrence is lacking in the Spanish term.[3] The original adjective 'chronic' thus refers to diseases that recur and last for long periods, and these features define migraine accurately.[4] Seen in this light, the adjective in Spanish does not specify a type of migraine but rather simply emphasises an intrinsic feature of migraine.

In fact, osteoarthritis, diabetes mellitus, and hypertension, to name a few, are also long-lasting disorders. However, to the best of our knowledge, these disorders are not referred to as chronic. *Migraña crónica* is a pleonasm, a figure of speech in which the adjective emphasises the features inherent to the noun, such as 'white snow' or 'black coal'.

This term has taken the place of other inappropriate and imprecise terms, such as transformed migraine, that were commonly used before the ICHD-3 was published. We understand that the term *migraña crónica* does not seek to be linguistically attractive but rather to emphasize the duration, recurrence, and severity of this disorder. However, these features are defined and quantified in the diagnostic criteria. According to logic, the name should convey the idea of exacerbation of the symptoms of an already chronic disorder.

In our view, 'exacerbation' or 'worsening of migraine' would be more appropriate terms. From a nosological viewpoint, chronic migraine is not that different from a

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hypertensive crisis, an acute episode of decompensated diabetes, or a bout of arthritic pain, although these episodes may last less time. There must be many other terms for this type of migraine which would more accurately reflect its nature, that is, symptom exacerbation in addition to chronicity.

However, this term is already well established and will therefore be very difficult to change. Unfortunately, *migraña crónica* is not a neologism; neologisms usually become accepted with time, especially in scientific settings. Rather, we find ourselves reinforcing a sort of false friend that should, at the very least, be unmasked.

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The 'three-hour effect' constitutes procrastination in thrombolytic stroke treatment☆

En la trombólisis del ictus el «efecto 3 horas» es procrastinación

Dear Editor:

It was with great interest that we read the study by Iglesias Mohedano et al.[1] addressing the factors associated with in-hospital delays in administering intravenous thrombolysis to patients with acute ischaemic stroke in a tertiary hospital. Curiously enough, one of the crucial factors associated with treatment delay in the multivariate analysis was onset-to-door time: the sooner patients arrive at the hospital, the longer they have to wait to receive thrombolysis once the CT study has been completed. The authors cite 2 articles dated 2011 and 2012 mentioning this phenomenon, which they call the '3-hour effect'.[2,3] However, this 3-hour effect is a function of the therapeutic window and should now be called the '4.5-hour effect', or the '6/8-hour effect' in the case of endovascular revascularisation.

In 2005, we proposed the term 'procrastination', that is, putting off a task unnecessarily and with no justification,[4] a very typical practice possibly resulting from laziness, which is probably not the case here, or reflecting the complexity and risks associated with a pending decision, as occurs with thrombolysis. Informally alerting our neurologists to the dangers of procrastination led to significant improvements, as we found some months later.[5] However, not all tertiary hospitals seem to be aware of procrastination and this faulty practice is still frequent: CT-to-needle time was longer in patients with shorter onset-to-door time, at least until the publication of the study by Iglesias Mohedano et al.[1] Specific emphasis should be placed on avoiding unnecessary delays, which can still be observed even after 20 years of thrombolytic stroke treatment. Even for patients within the therapeutic window, the sooner the treatment, the better.

Conflicts of interest

The authors have no conflicts of interest to declare.

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