1. Introduction
Migraine is the most prevalent brain disorder under age of 50 all around the globe and the first cause of disability due to severe headache and associated sensory disorders [1]. The characteristic features of pain are one sided, severe, pulsating headache attacks, worsening by daily movements and lasting 4–72 h. Accompanying sensorial symptoms suggesting hyperresponsivity in the somatosensory, visual, auditory, and olfactory systems are distinguishing features of migraine attacks and multisensory stimuli may worsen the headache severity [2]. Additionally, prior to the headache phase more pronounced sensorial disruptions can occur in the visual and somatosensory system such as scintillations, scotoma or paresthesia, numbness in the extremities. These slowly propagating sensory deficits are recognized as aura symptoms and implicated by underlying cortical spreading depression (CSD) waves [3].

2. CSD as a tool disconnecting the cortex from thalamus
CSD is a neuronal and glial depolarization wave that slowly propagates within the cerebral cortex, causing transient electrical and functional silence of the involved area. Propagation of massive depolarizations and accompanying electrical DC shift and regional blood flow increase along the cortex, left long-lasting decreased neuronal excitability and reduced regional blood flow behind [3, 4]. The sensory aura symptoms are considered solely due to cerebral cortical dysfunction by CSD. However, this conventional approach disregards several facts that i) propagation of CSD in gyrencephalic brains such as humans, primates and even felines is very restricted [4], ii) cerebral cortex functions in a synchrony with thalamus and brain network systems. In that sense CSD was essentially used to generate functional ablation of cerebral cortex in thalamic studies [4].

3. Hub function of higher order thalamic nuclei
Understanding the function of cerebral cortex requires knowledge of complex interaction between the cortex and the thalamus, known as thalamocortical network. The cerebral cortex and the thalamus operate in continuous interaction during the process of any information particularly related to somatosensory, visual and auditory sensory systems, movement, language, cognition and consciousness [5,6]. The thalamus sends projections to majority of the cerebral cortex, and receives cortical outputs in return. Thalamic nuclei transmitting peripheral sensory inputs to the primary cerebral cortical areas are considered as the first-order relay nuclei such as the ventral posteromedial (VPM) and lateral geniculate nucleus (LGN) that relay cephalic somatosensory inputs and visual stimuli respectively. Likewise, the higher-order thalamic nuclei receive inputs from the deep cerebral cortical layers and relay information from one cortical area...
4. Strategic role of thalamic reticular nucleus (TRN)

The deep cortical cells particularly from the 6th layer, also project to inhibitory neurons in the thalamic reticular nucleus (TRN) and modulate the frequency-dependent thalamic function [6–8]. The TRN consists of GABAergic inhibitory neurons and surrounds the dorsal thalamus. While the TRN exclusively projects to the thalamus and inhibits thalamic drive to the cortex, its neurons are driven by the first- and higher-order thalamic nuclei as well as the cerebral cortex [5,6]. TRN involvement during CSD was demonstrated in awake, consciously behaving experimental animals [9,10]. CSD induced SD waves were recorded in TRN and neuronal activation was demonstrated. It is likely that either SD in the cerebral cortex could provoke SD in TRN or SD waves propagate from cerebral cortex to the TRN, as subcortical structures are more susceptible compared to highly convoluted cerebral cortex in humans [4].

Involvement of the TRN may play a role in reduced sensory discrimination, lateral inhibition and increased response to sensory stimuli in different modalities such as light, sound and touch during migraine attacks. A subset of cortical deep projection neurons was shown to project selectively to higher order thalamic nuclei in mice and recently the higher order thalamic dysfunction was proposed to be involved in the development of migraine symptoms [4, 8].

5. Thalamocortical perspective to justify sensory symptoms

Instead of attributing sensory dysfunctions merely to the cerebral cortex, alternative view proposes a complex interaction of first- and higher-order thalamocortical areas along with TRN (Figure). A minimum critical volume of 1 mm³ rodent cortical brain tissue was estimated to be depolarized to ignite CSD [11]. Even if the propagation of CSD is blocked, such a depolarized cortical focus is sufficient to create a change in ongoing cortico-thalamic drive on thalamic relay nuclei and thalamic reticular nucleus. During CSD, abrupt cessation of cortical neuronal firing, would result in decreased excitatory glutamatergic drive from cortexo the thalamus, leading to a reduced GABAergic output from TRN on to thalamic relay nuclei and increased sensory impulses through thalamic relay to the cortex (Figure). That would account for the increased sensory excitation, sensory hyperresponsivity, reduced discrimination and reduced lateral inhibition and bidirectional role of sleep in migraine. Therefore, the processing of somatosensory stimulus and sensory discrimination was investigated in migraine patients [12–16]. For that purpose, somatosensory temporal discrimination (STD) test was employed. STD detects the temporal threshold to perceive two consecutive somesthetic stimuli as undoubtedly distinct [12–14]. STD was remarkably prolonged during the migraine attack while STD threshold values outside the migraine attacks were comparable to healthy volunteers [12]. STD studies also revealed that such a prolongation was specific to migraine attacks and was not detected during tension type headache, which is another common headache disorder [14]. It is an intriguing finding that discrimination of somatosensory stimuli applied to the hand that is transmitted through a pathway via thalamic ventral posterolateral nucleus (VPL), is disturbed during migraine attacks. Indeed, migraine headache is transmitted through a different pathway via trigeminal nerve to the thalamic ventral posterioromedial nucleus (VPM). Hence, it is unlikely that prolonged temporal discrimination of somatosensory stimulus applied to hand is merely mediated as a direct result of trigeminal nerve or thalamic VPM activation.

6. Interpretation of sensory dysfunctions in migraine

Transient impairment in the ability of discriminating the exact entry of somatosensory stimuli suggested a central processing dysfunction. Further study was conducted by short afferent inhibition (SAI) paradigm using transcranial magnetic stimulation [16]. SAI evaluates integration of somatosensory input through the thalamic relay neurons in the sensorimotor cortex. The SAI results revealed that impaired sensorimotor integrity and reduced cortico-cortical inhibition between somatosensory and motor cortices were associated with migraine attacks [16]. SAI impairment during migraine attacks, indicated a disinhibition in the sensorimotor integration. Remarkably, the facilitation of motor responses to a conditioned sensory stimulus was detected even several hours prior to the onset of migraine headache [16]. Therefore, the possible involvement of higher order centers seems undisputable.

In the higher order thalamic nuclei such as pulvinar, that would be manifested by the disrupted visual information processing and may be related to positive visual hallucinations superimposed on to a first-order incoming information, similar to the patients' visual auras [4]. Also, higher order visual areas and somatosensory areas are associated with medial and anterior part of the pulvinar that is a multimodal sensory integration area [17]. Therefore, loss of any incoming information by CSD from one of the interconnected cortical areas such as sensorimotor cortex or visual cortex to the pulvinar would change impulse trafficking and may yield multisensory sensory symptoms synchronously and/or sequentially.

7. Conclusion

Thus, the view of thalamocortical network dysfunction would clarify positive aura symptoms and simultaneously
manifestation of different symptoms related to distant cortical areas such as visual, sensorimotor and language cortices interconnected through a thalamic hub. Additionally, sensorial disruptions in more than one domain accompanying migraine headache can be attributed to multisensory integration dysfunction of the higher order thalamocortical network. Involvement of TRN would contribute sensory hypersensitivity in multiple sensory modalities, lateral inhibition and sensory discrimination problems associated with migraine headache. Additionally, activation of trigeminal pain nucleus through central pathways as a result of thalamocortical dysfunction could also contribute to the development of lateralized migraine headache.

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