**Biphasics Not Good Mix for Menstrual Migraines**

Low-dose, monophasic contraceptives seem to benefit migraine sufferers more.

**BY NANCY A. MELVILLE**  Contributing Writer

Scottsdale, Ariz. — Fluctuating hormones are believed to be the key culprit behind menstrual migraines, so low-dose monophasic oral contraceptives are generally the best alternative to help such patients, Christine Lay, M.D., said at a symposium sponsored by the American Headache Society.

Physicians often turn to biphasic contraception instead of monophasic pills in the belief that varying the hormone dosage will help alleviate menstrual migraines, but the dosage schedule can in fact make the problem worse, said Dr. Lay, a neurologist with the Headache Institute at Roosevelt Hospital, New York.

Dr. Lay gave the example of Mircette, which contains 21 days of 0.15 mg desogestrel/0.02 mg ethinyl estradiol, followed by 2 days of placebo pills and 5 days of 0.01 mg ethinyl estradiol.

‘I have numerous ob/gyns who put patients on Miretcele because they think it might help menstrually related migraines,’ she said. Instead, the method introduces another level of fluctuation of estrogen, and it is that fluctuation that is believed to trigger the migraines in the first place, said Dr. Lay. ‘It’s not whether the estrogen is present or absent, but it’s the change in estrogen and I find many patients don’t do well on Miretcele because of fluctuations in estrogen.’

Even worse for menstrual migraines are triphasic pills, which cause greater fluctuation in hormone levels and often are high-dose pills, Dr. Lay said.

‘The worst triphasic pills are the worst for migraine patients,’ she said. ‘Invariably you will have a patient track her calendar and over a month’s period of time she will report that within a day or two of switching to a new dose of pill, the woman will experience a migraine attack.’

Migraine patients generally fare much better when using monophasic low-dose (20 mcg) birth control pills, which offer a more uniform hormone level, Dr. Lay said. She added that the estrogen patch is another effective way of providing a more steady level of estrogen.

Newer non cyclical methods such as Seasonale (ethinyl estradiol and levonorgestrel) are also good alternatives for migraineurs, she said. ‘With a 91-day regimen, including 84 days of real pills and then the placebo pills, women skip perhaps three out of every four menstrual migraine attacks, because they’re not having a menstrual cycle,’ Dr. Lay said in an interview.

Estrogen use in patients who suffered from migraines was frowned upon for many years, but the International Headache Society Task Force on Combined Oral Contraceptives and HRT determined more recently that it was safe for migraineurs, provided that there are no other risk factors for coronary heart disease or vascular disease.

In addition, the migraine should be without aura and patients should be given the lowest effective hormone dose.

In the ebb and flow of hormone levels, it is the withdrawal of estrogen, specifically, that experts believe contributes to menstrual migraines.

History and Physical Critical in Secondary Headache Diagnosis

**BY ROBERT FINN**  San Francisco Bureau

Las Vegas — Even in a neurologist’s office, every headache patient merits a general history and a physical examination, which may be the best tools with which to differentiate secondary from primary headaches, John G. Edmeads, M.D., said at a symposium sponsored by the American Headache Society.

‘The headache never walks alone’ when it is secondary to a general medical condition, said Dr. Edmeads of Sunnymore Medical Centre, Toronto.

‘There’s always something on history or physical to give you a clue that there’s a general medical disease going on.’ And once you have this clue you can diagnose them through a focused work up that won’t cost an arm and a leg,’ he explained.

Dr. Edmeads offered the following suggestions:

► Neurologists can’t assume that patients have had a thorough evaluation before reaching their offices. Dr. Edmeads said that he has had patients ask about the blood pressure cuff as if they had never seen one before.

► Be suspicious if the patient’s signs and symptoms don’t clearly fit a traditional Headache Society criteria for primary headache. Any patient whose headache doesn’t meet the society’s criteria deserves additional investigation.

► If it’s not clearly migraine or tension type headache, look for evidence of central nervous system involvement, either in the brain or its coverings. If there’s any indication of CNS involvement, the next step includes neuroimaging and possibly examination of the patient’s cerebrospinal fluid.

► If there are no signs or symptoms of CNS involvement, then conduct a general medical screen. This should include a CBC, an erythrocyte sedimentation rate; electrolytes, including calcium and phosphorus; BUN and creatinine; liver enzymes and bilirubin; thyroid function studies, including TSH, T3, T4; and a chest x-ray. Answers will come back within a day or two and will cost less than a couple of hundred dollars, Dr. Edmeads said.

► If those studies are negative, consider serum protein electrohoresis and arterial blood gases. In general, consider carbon monoxide poisoning and test for cyanmethemoglobin. Carbon monoxide poisoning from poorly maintained heaters will often present as daily, diffuse, nocturnal headaches that clear up in the morning when patients get out into the fresh air.

► If all results are still negative, but you still have a headache, the headache is the result of a general medical condition, consider a consultation with a general internist.