Try Hormone Manipulation for Menstrual Migraine

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MIAMI BEACH — Up to 70% of women who experience migraines have exacerbations during menstruation, and another 7%-14% of female migraineurs experience only mensturally related migraines. Reducing the drop in estrogen levels that occurs at menstruation may help prevent migraines, said Dr. Susan Hutchinson, a poster presenter at the annual meeting of the Society for Adolescent Medicine.

Dr. Edwards said in a poster presentation at the American Headache Society symposium sponsored by the American Headache Society.

Women in oral contraceptives who experience migraines without aura, add-back estrogen delivered peri-menstrually when cycling off the active pills may help prevent menstrual migraines. Add-back estrogen can prevent the endogenous drop in ovarian estradiol production in women not using hormonal contraception who have menstrual migraines.

Physicians might consider using a 0.1-mg dose delivered via estradiol patch during the week of menses, said Dr. Hutchinson, a family physician and headache specialist in private practice in Calif. Lower doses tend to be less effective for this purpose, she added.

Young female migraineurs who ask for oral contraception should be advised of the “one-third rule,” which is that about a third of males who start oral contraceptive use have problems, and if they have the drug “simplified, with an odds ratio of 1.6. 87% follow-up rate. The QS method was the CS group, 89% had a past unplanned increase adherence and reduce pregnancies, including any method that would make their next period doesn’t start for an- other menstrually related migraines. Moreover, the QS method “simplifies the data really support [the idea] that one is pregnant.” Dr. Chan said in an interview. He noted that the findings are consistent with smaller studies that have shown better outcomes in patients treated by gynecologic oncologists. Drawing patients from multiple institutions, the new study provides more demographic detail, he said.

Investigators augmented registry data with chemotherapy information from a medical record review and a physician survey. Despite the extensive literature favoring treatment by gynecologic oncologists, two-thirds of the patients were treated by “other gynecologists,” a group that was not broken down but is presumed to include general surgeons and ob/gyns. Though the proportion of patients receiving sub specialist care increased from 28% to 36% during the period studied, it was still only 14% overall.

Compared with the larger group of women treated by other physicians, the women in the care of gynecologic oncologists were more affluent, more educated, and more often from urban areas. Poorer patients, especially from rural areas, were less likely to see a gynecologic oncologist. Looking for factors associated with suboptimal treatment of higher-risk, early-stage cancers, the researchers found 21% of younger patients (up to age 35) with stage I-II cancers did not receive chemotherapy; and only 39% of poorer patients and 38% of patients with early grade tumors received chemotherapy.

Younger patients who did not receive appropriate treatment were less likely to be classified as poor, less likely to be treated by a gynecologic oncologist, and had more early grade cancers,” Dr. Chan said.