Monophasic OCs Said to Ease Menstrual Migraines

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SCOTTSDALE, ARIZ. — Because fluctuating hormones are believed to be the key culprit behind menstrual migraines, low-dose monophasic oral contraceptives are generally the least effective, according to experts like Dr. Lay, M.D., who urge patients to seek alternative contraceptive methods.

In most cases, the teens had either voluntarily told their parents or they had come to the clinic at the suggestion of a parent.

“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, adding that the estrogen patch is another effective way of providing a more steady level of estrogen.

Newer non-cycling methods such as Seasonale (ethinyl estradiol and levonorgestrel) are also good alternatives for migraineurs, she 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. The withdrawal is believed not only to affect trigeminal pain pathways but also to have vasculature effects, but it may modulate neurotransmitters and magnesium, Dr. Lay said at the meeting.

The release of prostaglandin also plays a role in migraines, sensitizing peripheral nociceptors to pain and mediating hyperalgesia, and prostaglandin is known to increase during migraine attacks.

A key approach to treatment is having patients maintain a diary in which they track their menses and headache days, Dr. Lay said. The journal can help guide treatment options and determine the role of oral contraceptive use.

Since menstrual migraines can occur in young, otherwise healthy women, Dr. Lay strongly recommended using caution in approaching contraceptive issues.

“This is a critical time to discuss with patients pregnancy planning and medication contraindications in preg- nant teens. The use of these medications could make a patient wind up getting pregnant” unintentionally. “We recommend taking a patient off the pill when efforts to prevent migraines are unsuccessful,” Dr. Lay added.

“Physicians may have the patient go off the pill in order to observe the migraine pattern over time. However, the migraine pattern may not improve for at least 3-6 months. In such cases, it’s essential to talk about pregnancy issues if the patient is on the pill for contraceptive purposes.”

Short-term prophylaxis approaches recommended to prevent the onset of menstrual migraines range from nonsteroidal anti-inflammatory drugs, and for long-term prevention, Dr. Lay suggested considering standard preventive medications, including tricyclic antidepressant, antiepileptic drugs, β-blockers, and selective serotonin reuptake inhibitors.