Monophasic OCs Said to Ease Menstrual Migraines

BY NANCY A. MELVILLE

SCOTTSDALE, ARIZ. — Because fluctuating hormones are believed to be the key culprit behind menstrual migraines, low-dose monophasic oral contraceptives are generally not thought to be helpful in easing migraines, but the dosage schedule can 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 Mircette 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, said Dr. Lay.

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

“The 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, 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 vasoconstriction effects, but it may modulate neurotransmitters and magnesium, Dr. Lay said at the meeting.

The release of progesterol 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 pregnancy. Guidance of these patients could 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 monoestrogen patches, to LOEs, and some long-term prevention, Dr. Lay suggested considering standard preventive medications, including tricyclic antidepressants, anti-epileptic drugs, beta-blockers, and selective serotonin reuptake inhibitors.

Study: Parental Notification Laws May Lead to More Teen Pregnancies

BY MARY ELLEN SCHNEIDER

Senior Writer

Laws that require parental notification for teens to receive prescription contraception at family planning clinics could increase the risk of teen pregnancy, according to a study by Rachel Jones, Ph.D., and her colleagues.

“Family planning clinics need to be supported in the work that they are doing with teens,” said Dr. Jones, senior research associate at the Alan Guttmacher Institute (JAMA 2005;293:340-8).

The study found that if a law required clinics to inform parents in writing when their teenagers got prescription birth control, 18% of teens would have to refuse to continue taking the pill, said Dr. Lay.

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Consider Discontinuation of Hormonal Contraceptives to Reverse Sexual Dysfunction

BY KATE JOHNSON

Montreal Bureau

PHILADELPHIA — Discontinuation of hormonal contraceptives should be the first-line approach in addressing sexual dysfunction in women using these agents. Susan Sarajian, M.D., outlined her study of 20 women who experienced improved sexual function after discontinuing hormonal contraception.

“This is the first trial that correlates serum androgen changes with specific domains of sexual function,” she said at the annual meeting of the American Society for Reproductive Medicine.

About 15% of hormonal contraceptive users report sexual dysfunction in the form of low libido, vaginal dryness, impaired orgasm, and decreased arousal. “This may be the result of changes in serum androgens,” said Dr. Sarajian, a fellow in reproductive endocrinology and infertility at the University of California, Los Angeles, Medical Center.

Her study measured baseline total testosterone, free testosterone, and sex hormone-binding globulin (SHBG) in premenopausal women (mean age 34) who had been using hormonal contraceptives for at least 6 months. Most women had been taking oral contraceptives, but one had been using a contraceptives patch and one had been using contraceptive vaginal ring.

The serum levels were assessed again 4 months after the women discontinued using contraception. Patients also completed questionnaires at baseline and at the end of the study, which assessed sexual function, related distress, and sexual desire and energy.

Mean total and free testosterone levels increased, while SHBG rose significantly after contraceptive discontinuation. These changes coincided with an increase in sexual energy, decrease in sexual distress, and an improvement in global sexual function scores.

“There was significant improvement in arousal, lubrication, orgasm, and satisfaction,” she said, noting that the “anti-androgenic” profiles of hormonal contraceptives that are promoted by drug companies are not entirely beneficial.

But she says the fact that sexual dysfunction can be reversed with discontinuation of hormonal contraceptives is encouraging.

“We don’t recommend testosterone supplementation ad lib, or at all, until the cause of some one’s sexual dysfunction is investigated,” Dr. Sarajian said.