Teaching Course

HEADACHE

MENSTRUAL MIGRAINE and ESTROGEN ASSOCIATED MIGRAINE

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DISCLOSURE

NONE

Learning Objective

At the end of this session, the attendants should be able to:

- Describe the clinical features of menstrual migraine and other estrogen associated migraine
- Explain the pathogenesis and pathophysiology of menstrual migraine
- Describe the pharmacologic and non-pharmacologic management for menstrual migraine
- Select the appropriate abortive and preventive medication for menstrual migraine

Key message

- Menstrual migraine affects about 20–25% of female migraineurs in the general population, and 22–70% of patients presenting to headache clinics.
- Perimenstrual migraine attacks are associated with substantially greater disability than their non-menstrual attacks.
- Menstrual migraine consists of pure menstrual migraine and menstrually-related migraine.
- Pathophysiology: (1) decreased estrogen level; (2) release of prostaglandins from the endometrium into the serum; and (3) magnesium deficiency

Key message

TREATMENT

- **Acute therapies:** triptans (esp. frovatriptan) and NSAIDs (esp. mefenamic acid)
- **Preventive therapies:**
  - Long-term prevention therapy:
    - Standard prophylaxis: Standard migraine prophylaxis is appropriate for women with frequent menstrual and non-menstrual attacks.
    - Hormonal therapy: Continuous hormonal therapy either via continuous oral contraceptive pill without a break for menses or extended-cycle dosing of a transvaginal ring contraceptive may be effective.
  - Perimenstrual prophylaxis: 2 days prior to the onset of menstrual migraine and continued for a duration of 3 to 5 days
    - Triptans: frovatriptan 2.5 mg BID, naratriptan 1 mg bid, or sumatriptan 25 mg tid
    - NSAIDs: naproxen sodium (550 mg bid) and mefenamic acid (500 mg tid)
    - Estrogen therapy: 100-µg patch or 1.5-mg gel for a total of 7 days starting on day − 2 of menstruation
    - Non-invasive vagal nerve stimulation

Reference

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