DOCTOR ON CALL

Marilyn, a thirty-seven year old journalist living in Alexandria, Virginia writes:

"I've had it! While I've had migraines here and there at other times, since 8th grade I've had a severe migraine, lasting for days, every month when I have my period. For years, at least a fifth of my life has been consumed by these menstrual headaches. My mother had the same problem, and her migraines ended completely after menopause. Same thing with her mother. And my older sister.

I say, enough is enough. Why put up with this for another 10 year? I've had my children. I'm ready for a hysterectomy...and an end to these monthly migraines."

THE DOCTOR'S REPLY

Prior to puberty migraine is slightly more common in males, but from puberty onward the headache disorder is notable for its preponderance in females. By young adulthood the female:male ratio for migraine prevalence is 3:1, and only with the onset of menopause does this gender-related difference begin to diminish.

Migraine's tendency to affect women more than men has been attributed primarily to the influence that female sex hormones exert upon the biologic circuitry that generates migrainous symptoms. Put simply, one of the key contributors to migraine's preponderance in females is the fluctuations in estrogen levels that occur throughout much of a woman's lifetime.

One of the most common clinical manifestations of this hormonal influence is migraine's tendency to worsen just before and during menses. In "pure" menstrual migraine attacks occur only in conjunction with the menses. More commonly, actively cycling females with menstrually-related migraine (MRM) have attacks temporally related to menses and also at other times of the month.

A majority of actively cycling female migraineurs-up to 70%-report worsening of their migraine in association with menses. As a general rule, the headaches of MRM tend to be longer in duration and less responsive to acute treatment than headaches that occur at other times of the month; for some women, the menstrual week is marked by one long, continuous migraine. Once the MRM boulder starts rolling down the hill, its biologic momentum accelerates, making it hard to stop. Key to optimal treatment of MRM is stopping the migraine before it gets a chance to start.

Effective management of MRM typically involves the use of a calendar and headache diary. Tracking your migraine and menstrual cycle will help you identify when migraine occurs in relation to onset of flow. If there is a distinct pattern-say, migraine attacks usually begin the day prior to flow onset-and your cycles are regular and predictable, then anticipatory "mini-prophylaxis" can be utilized. A day or two prior to the anticipated onset of your MRM you can begin any one of a number of medications intended to prevent menstrual headache and continue that medication for the next 5 to 7 days, your "high risk" (for migraine) time. Medications commonly used for MRM mini-prophylaxis include magnesium oxide (400 milligrams (mg) once or twice daily-no prescription required), naproxen sodium (550-660 mg twice daily-available via prescription or over-the-counter) and frovatriptan (Frova; 2.5 mg twice daily-prescription only). Strangely, some women find that successful prevention of MRM with their mini-prophylaxis therapy may simply shift the prolonged migraine they avoided to the week following the end of menses.

The same acute migraine treatments you use at other times of the month may be

effective for MRM as well. Any of the 7 currently available oral triptans, Treximet (an oral compound containing brand Imitrex and naproxen sodium), intranasal zolmitriptan (Zomig), "exhalant" sumatiptan (Onzetra), various of the oral non-steroidal anti-inflammatory drugs (NSAIDs: egs, aspirin, naproxen sodium, ibuprofen, Cambia) and subcutaneously injected sumatriptan are reasonable options.

While elimination of menses may also eliminate MRM, **DO NOT** seek surgical menopause simply as a treatment for MRM. To their dismay, many women with MRM find that even following removal of their ovaries (and a consequent end to the cyclic fluctuations in levels of sex hormones) they continue to experience monthly episodes of week-long migraine that mimic their pre-surgical menstrual headaches. It's as if the brain has become "hard-wired" to MRM, and the "hard disc" will continue to signal cyclical periods of migraine headache even in the absence of peripheral stimuli (ie, estrogen shifts).

There are ways to suppress menses that are reversible and far less invasive than surgical resection of the ovaries. You can take an active oral contraceptive throughout the month, skipping the week of differently-colored inactive pills. You can use an estrogen-secreting IUD for contraception. You can become pregnant! Any of these may lead to cessation of MRM (definitely so in the case of pregnancy).

Don't let frequent headaches interfere with your child's daily life.

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