



Duquesne University Chapel



## PIC QUESTION OF THE WEEK: 5/12/08

Q: What are the current recommendations for the treatment of menstrual migraines?

A: In the United States, 20 million women experience migraine headaches, 60% of which are considered *menstrual related migraines* (MRM). In contrast to *non-menstrual migraines* (NMM), MRM headaches are more severe, last longer, and are less responsive to analgesics. Menstrual migraines are defined as headaches without aura that develop during the 5-day perimenstrual period (2 days before to 3 days after onset of menses). They must occur during at least 2 of 3 menstrual cycles, although they may or may not occur at other times during the month. It is hypothesized that MRM are triggered by falling levels of estrogen in the luteal phase of the menstrual cycle. This may explain why the incidence of migraines rises during the aforementioned 5 day perimenstrual period. MRM can be triggered by the same factors as non-menstrual migraines, for example, oral contraceptives, noise, lights, hunger, sleep disturbances, certain foods, alcohol, exercise, hypomagnesemia, and anxiety as well as by fluctuations in neurochemical and hormonal levels. Management strategies for MRM are similar to those used in NMM. Treatment is comprised of non-pharmacologic interventions as well as acute and preventive (either long-term or short-term) pharmacologic methods. Lifestyle changes such as reducing stress, sleeping and eating regularly, and exercise can reduce the development of MRM. The *triptans*, particularly sumatriptan, rizatriptan, and zolmitriptan, are considered first-line agents for treatment of acute MRM. While not labeled for migraines, NSAIDs such as mefenamic acid and naproxen are frequently used for this indication. Ergot alkaloids are effective in the treatment of MRM, but are not recommended due to potential adverse effects and the risk of rebound headache. For short-term preventive treatment of MRM, the triptans are given two days before to three days after the expected onset of menses. NSAIDs have also been used as prophylaxis against MRM. Transdermal application of estrogens such as estradiol (for a period of one week, beginning 2 to 3 days before menses) has also proven to be effective. Long-term prevention of MRM is similar to that for NMM and includes beta-blockers, anticonvulsants, antidepressants, magnesium, and hormonal therapies. There is little data to support the use of any specific drug for the long-term prevention of MRM. Quick and effective intervention can save a patient many headaches.

### References:

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