PRIMARY CARE
WOMEN'S HEALTH FORUM

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TOP TIPS

for Managing Migraine in the Menopause Transition

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1.

Empower women to recognise perimenopausal change in migraine: encourage headache diaries.

Migraine is a complex neurological condition that is affected by changes in our internal and external environments. Menstrually-related migraine (MRM) attacks are a predictor for worsening migraine in the menopause transition.[1,2] Attacks in the perimenopause are often longer lasting, more intense, and less responsive to treatment. Migraine may present or be recognised for the first time during the perimenopause.[2]

Early recognition of worsening migraine is an opportunity to review lifestyle and acute treatment, and to consider timely preventative treatment. Simple headache diaries are an invaluable tool for picking up change and response to treatment, (e.g. **www.nationalmigrainecentre.org.uk/headache-diary**)

2.

Four key questions to assess the impact of migraine and guide treatment:

1. How many headache/migraine days do you experience each month?
   If the answer is 15 or more: this may be chronic migraine.[3]
2. How many clear-headed days do you have each month?
   If the answer is under 15: consider chronic migraine. At face value, this question may look like an alternative way of asking question one, but there is more to it. People often do not recognise symptoms of migraine, and headache is not always the dominant symptom. Asking about clear-headed days adds information about the overall impact of the condition.
3. How many **days** do you take a painkiller or triptan to treat or prevent symptoms of migraine each month?
   If the answer is 10 or more, there may be medication overuse headache present.[3] Women in the menopause transition are at risk of medication overuse headache due to the changing nature of migraine and the demands of midlife.
4. How many days each month are lost due to migraine? This subjective measurement is not based on ICHD-3 [3] criteria but provides a useful indicator of impact and disability due to the condition.Lost days might include days spent in bed due to migraine, and/or days when work commitments or plans are cancelled because of migraine.

3.

Hormone replacement therapy (HRT) for perimenopausal women with MRM, *(suitable for women with a history of migraine with and/or without aura).*

For women with menstrually-related migraine that worsens in the perimenopause and who are experiencing **additional** intrusive perimenopausal symptoms, continuous combined hormone therapy regimens are better tolerated than cyclical regimens.[2,4,5] Transdermal oestrogen is preferred for this reason, and because there is little, or no increase in stroke risk or risk of venous thromboembolism (VTE) with this route of delivery.[2,6-8]

Estradiol patches provide a smooth oestrogen delivery system, and a levonorgestrel releasing intra-uterine system (LNG IUS) provides continuous progestogen for endometrial protection. The LNG IUS may also lead to amenorrhoea in a high proportion of women (70%) [9], and anovulation in some women (15%), both of which may help migraine. [2,5,10] It provides contraception making it a comprehensive option for many women. HRT regimens should be reviewed annually so that changes, such as the method of hormone delivery and the type of progestogen can be made when appropriate.

4.

An HRT regimen for women with MRM who want an alternative to an LNG IUS.

Alongside transdermal oestrogen, a continuous double dose of desogestrel (150mcg), can be considered for endometrial protection.[11,12] It also suppresses ovarian

activity and the hormonal ups and downs that can trigger migraine, provides contraception, and can help control perimenopausal heavy bleeding.

This is an unlicensed dose of desogestrel, but if reassurance about using a 'double dose' is needed, this dose is equivalent to the dose of desogestrel found in some combined pills, (e.g. Gedarel).

5.

Consider combined oral contraception (COC) for women with migraine without aura in the perimenopause (under 50).

For women who experience worsening menstrually-related migraine in the perimenopause, who have **no history of aura**, consider continuous combined oral contraception to the age of 50 if UKMEC appropriate. Packs can be taken continuously, stopping for four days if break-through bleeding occurs. This option offers stable hormone levels and suppresses ovarian activity, reducing oestrogen withdrawal migraine attacks. It also provides contraception and can help control perimenopausal bleeding problems. [2,5,13]

Women may need effective acute migraine treatment available to bridge the oestrogen withdrawal period; Naproxen 500mg twice daily or Frovatriptan 2.5mg twice daily could be considered.

6.

Migraine and post-menopausal hormone replacement therapy.

Continuous combined regimens using transdermal oestrogen and progesterone options including nightly micronised progesterone or an LNG IUS, or the combined patch (Evorel Conti) can be considered.[2,5] Tibolone is an option for post-menopausal women who experience migraine without aura, for example those women who are sensitive to progestogens or prefer an oral option.[2]

7.

Surgical/medical menopause.

Women with a history of premenstrual syndrome report a higher prevalence of migraine following surgical menopause compared to natural menopause [2], and surgical menopause with or without oophorectomy is associated with greater migraine-related disability.[8] Transdermal oestrogen is preferred in this context, with early consideration of migraine preventers. [2,5,8]

8.

Manage expectations.

1. Women with hormonally sensitive migraine often come to consultations with an understandable expectation that hormonal therapy is the solution. The right hormone therapy in the right individual can be helpful for both symptoms of menopause and migraine, but women should be counselled that hormonal treatment could make migraine worse.[2,8,15]
2. The dose of oestrogen should be titrated to the lowest effective dose to control menopausal symptoms, and not to treat the symptom of headache. Spikes in oestrogen can trigger attacks of migraine with aura: start with a low dose and build up gradually.[2] Start by offering patches, and if these are not tolerated or a woman has a strong preference for an alternative, move on to other transdermal oestrogen preparations such as gel or spray formulations.
3. Non–hormonal treatment may be an appropriate alternative. Options that bridge menopause and migraine care include SSRIs such as Escitalopram (10-20mg), or Venlafaxine (75-150mg).[2,5] Note that these are unlicensed indications.
4. Migraine often gets better after the menopause, but not always: it can be a lifelong condition. Women with migraine continue to be vulnerable to attacks of migraine and chronic migraine in later life.[2]

This guidance was correct at the time of publication. The PCWHF will undertake annual reviews of this guidance to ensure in it remains in line with best practice. The next review is due in December 2026. The guidance is for use by healthcare professionals only. DOP: December 2023. For further information, please contact: enquiries@pcwhf.co.uk

9.

Anti-CGRP migraine therapy and women: an up-date for GPs.

Calcitonin gene-related peptide (CGRP) is a neuropeptide that, in high levels, has been shown to trigger migraine in susceptible people.[16] There are oestrogen receptors throughout the migraine machinery (the trigeminovascular system), and although the precise relationships have not yet been established, oestrogen is known to influence CGRP levels.[17] There is evidence supporting the safety and efficacy of anti-CGRP therapy in women who experience menstrually-related migraine[18], and these medications will become more widely available to support women struggling with migraine in the menopause transition in the future.

Rimegepant is an oral CGRP receptor blocker which is effective treatment for aborting and preventing acute attacks of migraine. As an acute treatment, it is a once-a-day 75mg wafer that dissolves on the tongue. NICE have approved its use for people who have not tolerated two triptans, have not found two triptans effective, or who cannot use triptans.[19] It appears to be well tolerated, with a low side effect profile that includes nausea, (2%), and rare hypersensitivity reactions, (<1%). It does not appear to be associated with medication-related headache when taken regularly.[20] It is a medication that is to become available for GPs to prescribe and is a welcome additional treatment option for people who experience migraine.

10.

An approach to migraine care to share with your patients:

READY – Be prepared for migraine: self-care, keep a diary.

REACT – Treat acute migraine promptly with effective medication.[21,22]

RESTORE – Offer timely prevention, review, and referral if needed.[23]

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