The specialist authority for menopause & post reproductive health

Migraine and HRT

Introduction

Fluctuating estrogen levels and menstrual disorders are associated with increased migraine prevalence during the perimenopause. However, effective management of vasomotor symptoms can also result in improvement in migraine.

What are the key points about managing perimenopausal women with migraine?

- Perimenopausal women with no history of migraine aura may benefit from continuous combined hormonal contraception until age 50
- Migraine aura does not contraindicate HRT
- Use non-oral bio-identical estrogen (patch or gel)
- Use the lowest estrogen dose that effectively controls vasomotor symptoms
- Where progestogen is required continuous delivery is recommended, with preparations such as:
  - levonorgestrel intrauterine system
  - transdermal norethisterone (as in combined patches)
  - micronised progesterone
- Women with migraine and vasomotor symptoms who do not wish to use HRT or in whom estrogens are contraindicated may benefit from escitalopram or venlafaxine.

How do I know if a woman has migraine headaches?

Does she have episodic headache attacks lasting 4-72 hours?
If yes, then 'PIN' the diagnosis of migraine headache with ID-Migraine™

Photophobia	Does light bother her when she has a headache?
Impairment	Does she experience headaches that impair her ability to function?
Nausea	Does she feel nauseated or sick to your stomach when she has a headache?

If the answer to at least two out of three questions is 'yes' a diagnosis of migraine headache is likely.

How do I know if a woman has migraine with aura?

- Does she have visual disturbances that:
  - Start before the headache?
  - Last up to one hour?
  - Resolve before the headache?

If the answer to all three questions is 'yes' a diagnosis of migraine aura is likely.

What non-pharmacological options are there which have evidence of efficacy for management of vasomotor symptoms and prophylaxis of migraine?

- Regular exercise
- Weight loss

What pharmacological options are there which have evidence of efficacy for management of vasomotor symptoms and prophylaxis of migraine?

Treatment		Dose
Hormonal		
Post hysterectomy	Continuous transdermal estrogen	
Uterus intact: premenopause	Continuous transdermal estrogen plus LNG-IUS	
Uterus intact: postmenopause	– Continuous transdermal estrogen plus LNG-IUS – Continuous combined estrogen/ progestogen patches – Continuous transdermal estrogen plus micronized progesterone – Tibolone	Lowest estrogen dose required to control vasomotor symtoms
Non-hormonal		
SSRIs	Escitalopram	10-20 mg/day
SNRIs	Venlafaxine	37.5-150 mg/day

LNG-IUS, levonorgestrel intrauterine system; SSRI, selective serotonin reuptake inhibitor; SNRI, serotonin norepinephrine reuptake inhibitor.

Resources

For healthcare professionals – **www.thebms.org.uk**
www.bash.org.uk

For women – **www.womens-health-concern.org**
www.menopausematters.co.uk
www.managemymenopause.co.uk

References

Lipton RB, Dodick D, Sadovsky R, et al. A self-administered screener for migraine in primary care: the ID Migraine validation study. Neurology 2003; 61: 375–382.
MacGregor EA. Diagnosing migraine. J Fam Plann Reprod Health Care 2016; 42: 280–286.
MacGregor EA. Migraine, menopause and hormone replacement therapy. Post Reproductive 2018;24:11-18.

WE HAVE ALSO PUBLISHED A FACTSHEET AIMED AT WOMEN, WHICH IS AVAILABLE TO DOWNLOAD ON THE WHC WEBSITE:

https://www.womens-health-concern.org/help-and-advice/factsheets/migraine-and-hrt/

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