The specialist authority for menopause & post reproductive health

British Menopause Society

Migraine and HRT

Introduction

Perimenopause defines the time from when periods start to become irregular, typically mid-40s, through until 12 months after the final menstrual period. It is characterised by symptoms associated with fluctuating estrogen levels, menstrual cycle disorders and increased risk of migraine. However, these can be managed effectively with the right approach.

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

- Encourage lifestyle approaches including maintaining a healthy weight, regular aerobic and weight bearing exercise, a 'Mediterranean' diet, hydration and a regular sleep routine.
- A simple diary can identify an association between migraine attacks and menstruation.
- Consider menstrual cycle suppression during early perimenopause using continuous combined hormonal contraception (CHC):
  - to suppress the higher average endogenous estradiol levels and fluctuating spikes of estradiol that characterise early perimenopause compared to premenopause
  - to provide effective contraception
  - to manage perimenstrual migraine
  - to manage menstrual disorders
  - to manage menopause symptoms.
- Healthy women with migraine without aura can use continuous CHC containing ethinylestradiol until age 50.
- There is evidence that CHC containing estradiol (Zoely) or estetrol (Drovelis) have a safer thrombotic profile compared to ethinylestradiol but this is not yet reflected in the summaries of product characteristics.
- Women with migraine aura or who have other contraindications for ethinylestradiol and women over age 50 can use the drospirenone progestogen-only pill ± transdermal estradiol (off licence) until age 55, by which time ovarian estradiol activity has declined sufficiently in most women to no longer trigger migraine.
- During late perimenopause/early postmenopause continuous combined hormone replacement can be considered to manage vasomotor symptoms in women with migraine:
  - transdermal estradiol (patch/gel/spray) is preferred where possible as it provides more stable levels compared to oral estradiol
  - migraine aura does not contraindicate hormone replacement therapy

  However, in view of the possibility of irregular bleeding from the natural cycle not being suppressed, cycle suppression may be more appropriate.
- Women continuing HRT postmenopause should be advised that they are less likely to benefit from the gradual decline in migraine over the years that follow natural menopause seen in women who do not take HRT.

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- The optimal estrogen dose for women with migraine is the lowest dose that effectively controls vasomotor symptoms; high doses can be associated with increased headache and migraine.
- In women who do not wish to use HRT or in whom estrogens are contraindicated, escitalopram or venlafaxine can benefit both migraine and vasomotor symptoms.

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 vomit when she has a headache?

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

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

Around one-third of migraine headaches are preceded by an aura characterised by transient, reversible neurological symptoms. Over 90% of auras are visual but 20-30% of auras comprise sensory and/or language symptoms. The specific symptoms of aura should not be confused with vague premonitory symptoms such as blurred vision, which can start several hours rather than within an hour of the onset headache and which persist through the headache rather than resolving before or at the onset of headache.

Does she have visual disturbances that:

- start **before** the headache?
- look like zigzag lines?
- persist with the eyes closed
- last up to one hour?
- resolve **before** the headache?

If the answer to the majority of questions is 'yes', a diagnosis of migraine aura is likely.

In case of doubt, show the Mayo Clinic YouTube depiction of migraine aura:
https://www.youtube.com/watch?v=qVFIcF9lyk8

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

- Regular aerobic exercise
- Obesity management
- Cognitive behavioural therapy

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

Treatment		Dose
Hormonal		
Post hysterectomy	Continuous transdermal estrogen	Lowest estrogen dose required to control vasomotor symptoms
Uterus intact: perimenopause	**Migraine without aura** • Continuous CHC (skipping the hormone free interval) • Consider CHC containing natural estrogen e.g. Drovelis or Zoely as scientific evidence supports lower risk of thrombosis **Migraine aura/contraindications to CHC** • Drospirenone 4 mg POP ± transdermal estradiol • If estradiol used (off licence) in addition to drospirenone POP, skip the 4 placebo pills	
Uterus intact: postmenopause	• Continuous transdermal estradiol plus 52 mg LNG-IUD • Continuous combined transdermal estradiol/ progestogen patches • Continuous transdermal estrogen plus oral micronised progesterone • Tibolone (under age 60)	
Non-hormonal		
SSRIs	Escitalopram	10-20 mg/day
SNRIs	Venlafaxine	37.5-150 mg/day

LNG-IUD: levonorgestrel intrauterine device; 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
https://shows.acast.com/menopause-matters-lets-talk/episodes/migraines-menopause-and-hrt-what-a-combination

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This BMS Tool for Clinicians will be updated when guidance changes and/or new data becomes available.

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