MIPCA
MIGRAINE IN PRIMARY CARE ADVISORS
NUMBER 17 — MARCH 2008

News from MIPCA

New web-based educational modules

MIPCA is proud to launch a new educational initiative that is available to all members on our website, www.mipca.org.uk. The initiative has the overall theme of "Headache Building Blocks", and provides interested GPs, nurses, pharmacists and other healthcare professionals with a basic course on headache management in primary care. We have produced seven modules, containing slides, explanatory notes and references (Table 1).

Module number	Title	Course content
1	Clinical features of migraine and other headaches	1. Headache classification 2. Epidemiology 3. Pathophysiology 4. Clinical features of migraine
2	Comorbid illnesses associated with migraine	1. Psychiatric disorders 2. Cardiovascular disorders 3. Other comorbidities 4. Clinical implications
3	Diagnosis of headache	1. Consulting patterns for headache 2. Headache classification for the GP 3. Diagnosing headache in primary care
4	Principles for the management of headache in the clinic	1. First principles 2. Principles of headache management in detail 3. '10 Commandments' of headache management
5	Acute treatments for migraine	1. Evaluating the efficacy of acute treatments 2. Evidence for analgesic-based treatments 3. Evidence for the triptans 4. Advanced treatment strategies 5. Treatment algorithms 6. Future treatments
6	Preventive treatments for migraine and chronic daily headache	**Migraine** 1. Non-drug treatments 2. Prescribed preventive treatments 3. Complementary therapies 4. Treatment algorithms **Chronic daily headache (CDH)** 1. CDH management
7	Development of a 'GP Toolkit' for headache management	1. Screening tools 2. Tools for diagnosis 3. Tools for initial management 4. Tools for ongoing management 5. MIPCA treatment algorithms

On completion of the course, healthcare professionals should have the basic knowledge needed to manage headache in primary care. Each module contains several quizzes, and students who complete these successfully can download certificates which can be used to aid in their professional development.

The website course also acts as a primer for the Postgraduate Certificate course, Headache Management in Primary Care run by MIPCA in conjunction with the University of Central Lancashire (UCLan), which is now enrolling students. This is available as a web-based course from the outset. Interested members should contact UCLan directly for further information and an application pack by phone on 01772 893805 or by email at healthcourses@uclan.ac.uk.

Joint symposium with Primhe

Unfortunately, the joint symposium between MIPCA and Primhe (Primary care mental health and education) on 'Wired for Health' advertised in our last issue had to be cancelled at short notice. We hope to arrange a new date for this in the near future. Please visit the MIPCA website (www.mipca.org.uk) for news.

Future MIPCA newsletters

Owing to increased production and postal costs, this is the last MIPCA newsletter that will be distributed by post. Future issues (two or more per year) will be circulated electronically as PDF files. To receive copies by email, please send your email address to our secretariat at info@mipca.org.uk. As before, all newsletters will be news items and posted on the website (www.mipca.org.uk), from which they can be downloaded.

Managing menstrual migraine in primary care[1]

Menstrual migraine is a common condition, affecting most female migraine sufferers. However, it is often poorly understood by healthcare professionals. Management involves the same principles and medications as are used for general migraine attacks and, overall, there should be few problems in managing all migraine attacks in women in primary care.

Introduction

This brief article provides guidance for the healthcare professional on managing menstrual migraine based on the best available clinical evidence. The article is based on literature searches (MedLine and congress presentations up to September 2007) and presentations and discussions at a MIPCA meeting held on 23 March 2007.

Definitions of menstrual migraine

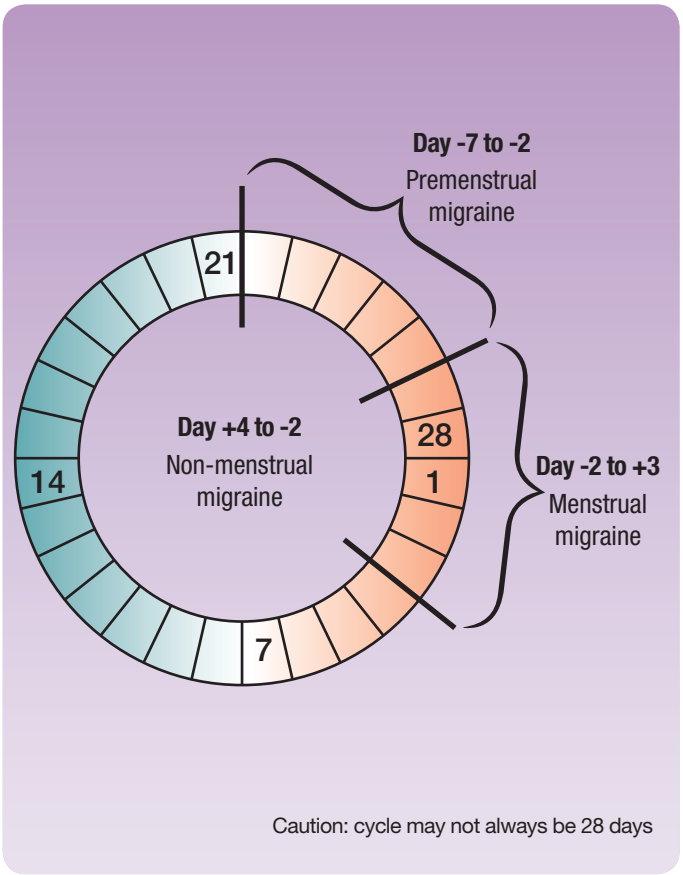

Figure 1. Definitions for menstrual migraine

- Women often report that all or nearly all their migraine attacks occur at menstruation, but studies demonstrate that this is a misconception and that attacks typically occur at all times in the menstrual cycle. Accurate definitions of menstrual migraine are therefore important for appropriate treatment to be given (Figure 1).
- Attacks of menstrual migraine are defined as those occurring on days -2 to +3 of menses (although may start earlier than or finish later than these arbitrary time points).
- 'Pure menstrual migraine' is defined as attacks occurring only on days -2 to +3 of menses.
- 'Menstrually-related migraine' is defined as menstrual migraine attacks occurring in two out of three cycles, but also at other times.
- 'Premenstrual migraine' is defined as attacks occurring on days -7 to -2 before menses.

Only attacks of migraine without aura are related to menstruation. Headache diaries should be used to differentiate attacks of menstrual migraine from attacks at other times.

Epidemiology and pathogenesis

- Most female migraine sufferers have an increased frequency of attacks associated with the menstrual period:
  - Prior to the menses in women with premenstrual tension
  - During menses in most other women, with no postmenstrual or ovulatory increase.
  - The risk is highest at the start of menstruation.
  - Pure menstrual migraine is uncommon.
- Menstrual migraine attacks are significantly more frequent than those occurring outside the menstrual period. There is also a tendency for menstrual migraine attacks to be more severe than attacks at other times.
- The pathogenesis of menstrual migraine is due to falling oestrogen levels which occur at menstruation. There is the hypothesis of perimenstrual but not postovulatory oestrogen 'withdrawal' migraine. Overall, rising levels of oestrogen appear to offer some protection against migraine.

Treatments for menstrual migraine

Treatment strategies (Figure 2)

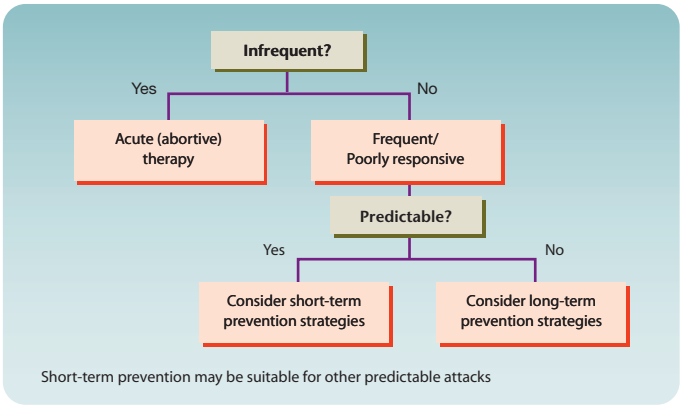

Figure 2. Treatment strategies for menstrual migraine

There are three main strategies for treating menstrual migraine attacks:

1. Acute treatment alone can be given for infrequent attacks.
2. Short-term prevention plus acute treatment may be used if migraine attacks predictably occur during menstruation
3. Long-term prevention plus acute treatment may be used where attacks are unpredictable and occur throughout the menstrual cycle.

In treating menstrual migraine, use of a headache diary is critical, to track the menstrual cycle and days with headache.

Acute treatments

- In general, the acute treatment of menstrual migraine attacks is the same as that of general migraine attacks, and triptans and analgesic-based therapies can all be used.
- Randomised, placebo-controlled studies (Grade A evidence) demonstrate that sumatriptan, zolmitriptan and naratriptan tablets are effective treatment for menstrual migraine (Figure 3).

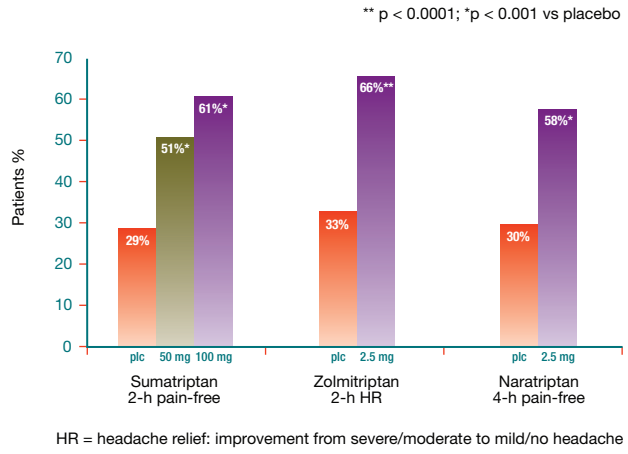

Figure 3. Efficacy of oral triptans treating menstrual migraine attacks from randomised, placebo-controlled studies

- Retrospective and open-label studies (Grade B clinical evidence) indicate that subcutaneous sumatriptan, and oral rizatriptan, almotriptan, zolmitriptan, frovatriptan and aspirin plus paracetamol plus caffeine (AAC: similar to Anadin Extra®) may all be effective in menstrual migraine (Figure 4).

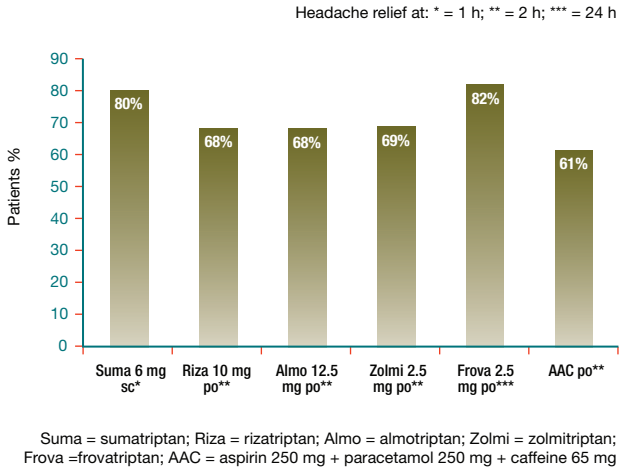

Figure 4. Efficacy of triptans and analgesics treating menstrual migraine attacks from retrospective or open studies

- Efficacy of these drugs in menstrual migraine attacks is similar to that reported for non-menstrual attacks.

Short-term prevention

- Short-term prevention is given for several days each month with the aim of preventing the development of menstrual migraine. Treatment is given for 5–7 days, beginning before the anticipated start of the menstrual migraine. Data from randomised, placebo-controlled, Grade A clinical studies are fully published for naratriptan and frovatriptan.
- Four cycles of naratriptan (1 mg or 2.5 mg) or placebo were given to 206 patients twice daily for 5 days, starting 2 days prior to the expected onset of menstrual migraine. The primary endpoint was the number of menstrual migraine attacks that occurred over the four cycles. Results (Figure 5) showed that significantly more patients receiving naratriptan 1 mg than placebo had ≤50% of perimenstrual periods with headache.

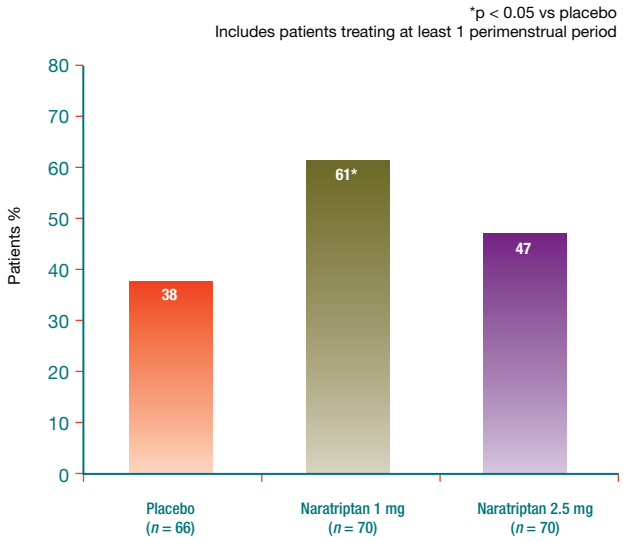

Figure 5. Short-term prevention of menstrual migraine attacks with naratriptan: patients with ≤50% of perimenstrual attacks with headache

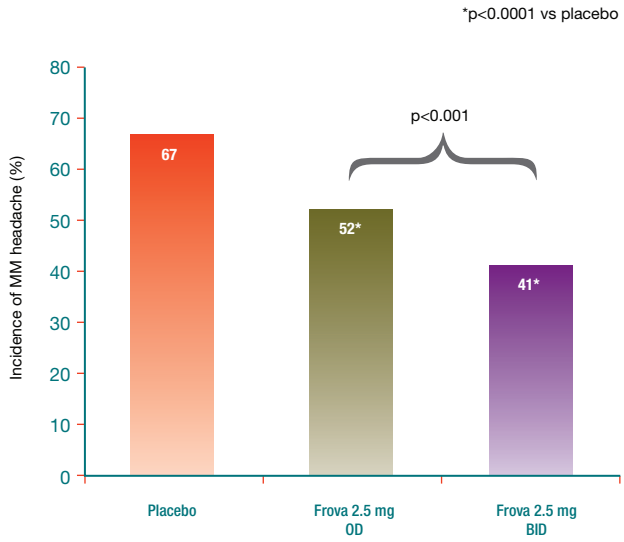

Figure 6. Short-term prevention of menstrual migraine attacks with frovatriptan: incidence of menstrual migraine during 6-day preventive treatment around the menstrual period

- Women ($n = 546$) were treated for each of three perimenstrual periods with placebo, 2.5 mg frovatriptan once daily or 2.5 mg frovatriptan twice daily, for 6 days starting 2 days before the anticipated start of menstrual migraine. Patients received a double dose of frovatriptan on the first treatment day. The primary endpoint was the incidence of menstrual migraine during the 6-day treatment period. Results (Figure 6) showed a significantly reduced incidence of migraine following frovatriptan compared with placebo, with the best results obtained from the twice daily dose.
- Zolmitriptan was also shown to be effective in short-term prevention, although the study is only published as an abstract to date. Sumatriptan gave equivocal results in small studies.
- Studies with other drugs for short-term prevention are inadequate to properly assess their efficacy.

Continuous prevention

- As with acute treatments, conventional preventive drugs can be used for menstrual migraine, although there are no clinical studies investigating this indication.
- Beta-blockers and topiramate may both be used. Increased dosages may be given during the perimentrual period, as an increased frequency and severity of migraine attacks are seen at this time. However, there is an increased risk of side effects with the higher doses used. As in conventional migraine treatment, comorbidities should be considered in prescribing the most appropriate therapy.

Conclusions

- A high proportion of female patients on a GP's list will suffer from attacks of menstrual migraine.
- Menstrual migraine attacks are generally more frequent and severe than those occurring at other times.
- Fortunately, management strategies for menstrual migraine are the same as those for general migraine attacks and there should be few problems in managing all migraine attacks in women in primary care.

Reference

1. Dowson AJ et al. Managing menstrual migraine and other headaches experienced by women. Headache Care 2008; in press.

If you are interested in joining MIPCA please visit www.mipca.org.uk or contact Ms Rebecca Salt, Merrow Park Surgery, Kingfisher Drive, Merrow, Guildford GU4 7EP: Tel 01483 450755: Fax 01483 456740.