Conflicting terminology in the context of migraine

Having read the January 2007 issue of the Journal with the very interesting and well-written article on menstrual migraine by Anne MacGregor, I was surprised to read the words ‘flickering lights’ (Box 1; 1.2.1 Typical aura with migraine headaches B.1.) in the context of migraines with aura.

This is confusing as the UK Medical Eligibility Criteria for Contraceptive Use seems to have a different perspective on neurological symptoms and signs. If a feature such as ‘flickering lights’ is a symptom of migraine with aura, it should be classified in the International Headache Society (IHS) criteria for migraine with aura. If it is not a symptom of migraine, then why is it being used?

I was also surprised to read ‘flashing lights’ in the context of migraines with aura. The CEU classification states that motor weakness is not a symptom of migraine with aura and is not a feature of typical migraine. However, motor weakness is a feature of the rare dominantly inherited condition ‘familial hemiplegic migraine’ which is not a feature of typical migraine with aura.

I suggest that the CEU classification should be reevaluated to ensure that ‘flickering lights’ or ‘flashing lights’ are included as a symptom of migraine with aura. However, before the headache; ‘flashing lights’, blurring of vision, or photophobia of variable duration before or with the headache are considered to be migraine aura and are not suggestive of focal ischaemia.

If ‘flashing lights’ are taken out of this context it is misleading. UKMEC does state that “auras occur before the onset of headache” but even this needs further clarification. I suspect UKMEC is trying to distinguish between generalised visual disturbances, which can include ‘flashing’ or ‘flickering’ lights that are normal prodromal symptoms of migraine. These occur up to 24 hours before the onset of headache and can last throughout the attack. They are quite different from the specific visual ‘flickerings’ of aura, which start before the onset of headache, last up to an hour (usually around 20–30 minutes) and resolve before the onset of headache.

With respect to the FPPRC statement that “symptoms of aura include … unilateral weakness,” I can confirm that although motor weakness is a feature of the rare dominantly inherited condition ‘familial hemiplegic migraine’ it is not a feature of typical migraine with aura. If symptoms in the extremities occur during aura, they are sensory, such as pins and needles or numbness, often spreading up one arm and into the face. Sensory symptoms are almost always associated with visual symptoms. Hence a simple screen for migraine with aura is:

- Do you have visual disturbances:
  - Starting before the headache?
  - Lasting up to one hour?
  - Resolving before the headache?

If the answer to all three questions is ‘yes’, it is likely that the symptoms are aura.6 Aura can occur without subsequent headache but the nature and duration of the aura is unchanged.

The reason to be concerned about aura is the increasing body of evidence of an increased risk of ischaemic stroke if initial attacks were migraine with aura (OR 8.38, 95% CI 2.33–30.1) suggesting that even a distant past history is associated with increased risk.

As UKMEC recommends the onset of migraine aura during CHC use should remain an absolute contraindication to continuing this method of contraception but I am unclear as to why this recommendation for continuing progestogen-only methods. I refer to my letter published in the Journal in response to the National Institute for Health and Clinical Excellence (NICE) guidelines on long-acting reversible contraception (LARC), in which I noted that in contrast to CHCs there is evidence that use of progestogen-only methods is not associated with increased risk of ischaemic stroke.5,8 Hence, there is no reason why these methods should not be continued if appropriate methods of contraception.

Our role is to help women choose safe and effective contraception. It has been said that “contraceptive methods have not failed the woman, the woman has failed contraceptive products may lead women to use them less than effectively or not at all.”10 Contraceptive failure rates are justifiable since there is evidence of risk and contraceptive efficacy need not be compromised, as other methods are equally, if not more, effective. Since the use of CHCs is associated with increased ischaemic stroke, it would be inappropriate to restrict these in the absence of evidence of harm.

In my earlier letter, I recommended that both NICE and the World Health Organization should consider migraine aura to be Category 2 for both initiation and continuation of all progestogen-only methods. I request that the Faculty of Family Planning and Reproductive Health Care also considers this recommendation.

E. Anne MacGregor, MFFP
Director of Clinical Research, The City of London Migraine Clinic, London, UK.
E-mail: anne.macgregor@sinoragmail.co.uk

References
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Antje Ischebeck

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