Menstrual migraine

I read with interest Dr Anne MacGregor’s review on menstrual migraine in the January 2007 issue of the Journal.1

On page 44, under the title ‘Perimenstrual oestrogen supplements’, Dr MacGregor explained when and why oestrogen supplements are not recommended. The use of perimenstrual oestrogen such as transdermal oestrogen (100 µg daily) in the perimenstrual phase is falling into disuse because of the apparent synergism between migraine and contraceptive oestrogen as risk factors for stroke.2 I think other forms of oestrogen that are not a component of a contraceptive method are not free of such risks. The Members’ Enquiry Response3 and myself were surprised by the guidance from the Faculty.4 It is my understanding that the risk of oestrogen replacement in women with migraine with aura in a review in this issue of the Journal.5 Also important is the different pathophysiology of migraine with aura compared to migraine without aura, with respect to oestrogen. Although both forms of oestrogen are often associated with the development of aura, withdrawal of oestrogen precipitates migraine without aura.6 This only serves to diminish even more the patient’s right to choose.

In one patient with menstrual migraine, I used a non-steroidal anti-inflammatory drug, as a prophylactic, which delayed the migraine to other times of the cycle. The patient is currently well controlled on gabapentin. As patients with menstrual migraine within aura if they have more than one additional risk factors for stroke such as age over 35 years, smoker or obesity.

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Reply

I am grateful to Dr Al-Hassan for giving me the opportunity to clarify the safety of oestrogen supplements for the prevention of menstrual migraine.

As mentioned in the review, compared to non-menstrual attacks, menstrual migraines are more severe, have a greater impact on quality of life and are less responsive to symptomatic treatment and more likely to relapse.7 Prophylaxis for menstrual migraine is indicated when acute therapy does not adequately control symptoms.8 Short-term perimenstrual prophylaxis is a target intervention to the time of need, limiting potential side effects of medication to a few days rather than throughout the cycle. As Dr Al-Hassan emphasises, it is important that such treatments are safe.

Regarding the concern about migraine aura, menstrual migraine is, by definition, without aura so the issue of using oestrogen supplements for this condition is of less concern. The Faculty requires that for the issue of using oestrogen supplements to bridge the interval between the luteal phase oestrogen decline and the follicular phase rise, a recommended dose of oestrogen, 100 µg patches provide plasma levels of oestrogen of the order of 382 ± 232 pmol/l (i.e. maintaining luteal phase levels).9 On this basis, the risk of ischaemic stroke associated with perimenstrual supplements should be no greater than the risk associated with the normal menstrual cycle.

In contrast to physiological doses of natural oestrogens, combined hormonal contraceptives (CHCs) contain potent synthetic oestrogens in order to suppress ovulation. Even when taken by healthy women, CHCs are associated with a small but measurable increased risk of ischaemic stroke. This risk has not been shown for natural oestrogens used by perimenopausal women.10 It is unclear why, in their evidence-based response, the Clinical Effectiveness Unit has extrapolated data regarding increased risk of ischaemic stroke in women with migraine associated with use of CHCs to imply that there is an association with use of physiological doses of natural oestrogens.11 In addition, there is evidence that risk of stroke is associated with frequency of migraine, one of the reasons that preventing attacks might be associated with reduced risk.12

On that note, Dr Al-Hassan remarks on delayed migraine with aura and perimenstrual prophyaxis with non-steroidal anti-inflammatory drugs. This has also been shown with perimenstrual prophylaxis with oestrogen and with naproxen.13 From a clinical perspective, although this can be a problem for individual women, it is not a problem for all. It is usually resolved by extending the duration of perimenstrual prophylaxis and tapering the dose or, as Dr Al-Hassan correctly notes, by continuous prophylaxis.

Finally, prohibiting use of CHCs in women with migraine without aura who have more than one additional risk factor for stroke has been the standard recommendation for a number of years, and was based on the evidence available at the time.14 In light of new research, there is increasing evidence to suggest that the risk of ischaemic stroke associated with migraine without aura is not significant.15 Hence, my recommendation is that there is no reason to restrict use of CHCs by healthy, non-smoking women over the age of 35 years who have migraine without aura.

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References


Review of abortion laws

Ann Furedi1 is the most recent voice to call for a review of the 1967 Abortion Act,2 seeking to set aside some of the checks and balances, which she believes are restrictive. Others, however, feel the laws are too liberal and should be tightened.3 Whatever might have been behind the Act, it was well crafted with the interest of the woman uppermost and remains as good and relevant today despite its age. There are sufficient checks and balances in place to allow women access to terminate unwanted pregnancies, by trained people who want to provide the service in a regulated premises to ensure safety and avoid morbidity. The Act does not need amending either one way or the other. Advantages in medicine are occurring all the time and some of these have been incorporated into providing abortions without a need to amend the Abortion Act (e.g. nurse and medical abortions).

There is concern, however, that numbers of terminated pregnancies continue to rise4 and therein lies the problem, the solution of which is not to amend the Abortion Act but to ensure that women wanting to terminate pregnancies become pregnant as a result of non-use or poor use of contraception.5 More effort needs to be put into preventing unwanted pregnancies in the first place by effective and reliable contraception. If there were no unwanted pregnancies there would be no requests for terminations of pregnancy. The National Institute for Health and Clinical Excellence (NICE) has recommended long-acting, reversible contraceptives of choice,6 yet these remain poorly promoted and not readily available to women for many general practitioners do not provide the full range of these methods.7 Furedi8 attempts to draw parallels between the rights of competent pregnant women to refuse

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Caesarean section and the competent pregnant woman to have abortions. While the two scenarios may appear similar, they are in fact very different and cannot really apply. While a competent pregnant woman can always expect to have her refusal of the offer of a Caesarean section respected, a competent pregnant woman cannot at all times expect to have her request for a termination of pregnancy to be honoured.

The abortion law as it stands now is robust enough to prevent any amendments. The delivery of abortion services may be poor in some areas. The solution in such areas is to implement guidelines published by the Royal College of Obstetricians and Gynaecologists (RCOG),4 which should ensure a high-quality service nationwide, rather than seek to amend the Abortion Act.

Abortion is an emotive issue for all concerned. We should direct our energies towards reducing the numbers of women seeking abortions by implementing the NICE guidelines on LARC nationwide. This approach will yield better results than an amendment of the Abortion Act.

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References

Reply

Umo Esen is right to argue that the Abortion Act 1967 was "well crafted", and my earlier article concurred that it has "served women, and their families reasonably well."1 It is also true that a liberal interpretation of the law has enabled women to access a termination as early as 4 weeks of dispatch of that issue to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office, Faculty of Family Planning and Reproductive Health Care, 27 Sussex Place, Regent's Park, London NW1 4RG, UK.

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