Try Hormone Manipulation for Menstrual Migraine

BY SHARON WORCESTER
Southeast Bureau

MIAMI BEACH — Up to 70% of women who experience migraines have exacerbations during menstruation, and another 7%-14% of female migraineurs experience only menstrually related migraines.

Reducing the drop in estrogen levels that occurs at menses—whether the drop is endogenous or exogenous—can help these women, Dr. Susan Hutchinson said at a symposium sponsored by the American Headache Society.

In women on oral contraceptives who experience migraine without aura, add-back estrogen delivered perimenstrually when cycling off the active pills may help prevent menstrual migraines. Add-back estrogen can also prevent the endogenous drop in ovarian estradiol production in women not using hormonal contraception who have menstrual migraines.

Physicians might consider using a 0.1-mg dose delivered via estradiol patch during the week of menses, said Dr. Hutchinson, a family physician and headache specialist in private practice in Irvine, Calif. Lower doses tend to be less effective for this purpose, she added.

Young female migraineurs who ask for oral contraception should be advised of the "one-third rule," which is that about a third of migraineurs who start on oral contraception experience improvements, about a third have no change, and about a third have deterioration.

However, the best options in those with regular menses include low-dose (35 mcg of estrogen or less) monophasic birth control pills, or contraception delivered via a contraceptive ring.

For prevention in those who still have menstrual migraines, physicians should consider continuous monophasic contraception or continuous contraception via vaginal ring with estradiol add-back when cycling off.

However, Dr. Hutchinson warned that the World Health Organization and the American College of Obstetricians and Gynecologists consider estrogen-containing contraception contraindicated in women who have migraine with aura, because studies have shown an increased stroke risk in this population.

The risk is further increased in those who use hormonal contraceptives and who have other risk factors such as smoking, hypertension, and dense aura.

In women who experience aura only rarely, the benefits of estrogen-containing contraception may outweigh the risks, so treatment decisions should be made on an individual basis, Dr. Hutchinson said.

In those who experience aura with migraine, options include progesterone-only oral contraceptives, implants, or injections, and progesterone or copper IUDs.

All migraine patients whose hormonal status is altered should keep a journal or calendar tracking headaches to ensure appropriate treatment, she noted.

"Understanding the relationship between hormones and migraine is instrumental. …If we really want to help our women migraineurs, particularly the 60%-70% [whose headaches worsen] during the time of their period," said Dr. Hutchinson. ■

Preventive Strategies May Work for Nonresponders

Women with menstrual migraines who fail to respond adequately to hormonal manipulation may benefit from short-term or minipreventive treatment approaches, Dr. Hutchinson said.

For example, NSAIDs given for short periods or just before menstruation can be helpful for reducing frequency and/or severity of migraines. Triptans are also useful for menstrual migraines, but many women who use triptans express concerns about having to use so many for this indication, because menstrual migraines tend to last longer and have greater severity than other migraines. In these patients, combining hormone manipulation with triptan treatment may help.

Combining an NSAID and triptan can also be a useful approach; some patients report that this combination works even better and faster than triptans alone.

Magnesium has also been shown to have some preventive benefit when given at 400 mg during the luteal phase or daily (a simpler approach). Increasing the dose of daily preventive medications around the time of menstruation can also be useful, Dr. Hutchinson said.

Start Teens on OCs ASAP to Achieve Optimal Adherence

BY JOHN R. BELL
Associate Editor

DENVER — Starting adolescent girls immediately on oral contraceptives without waiting until the next menstrual period improves continuation to the second pack of pills and beyond, Dr. Sharon M. Edwards said in a poster presentation at the annual meeting of the Society for Adolescent Medicine.

Dr. Edwards, a pediatrician at Mount Sinai School of Medicine, New York, and her colleagues enrolled 539 girls (mean age 16 years) in a prospective nonblinded randomized controlled trial to determine if starting OCs during the initial clinic visit in girls who test negative for pregnancy, regardless of menstrual cycle, would increase adherence and reduce pregnancies. The girls had presented to two large inner-city clinics requesting OCs.

A total of 267 patients were assigned to OCs with a conventional start (CS) and 272 to the "quick-start" (QS) method. In the CS group, 89% had a past unplanned pregnancy, as had 90% of the QS group.

The investigators assessed each group at 3 and 6 months after baseline with an 87% follow-up rate. The QS method was associated with second-pack OC continuation, with an odds ratio of 1.6.

Moreover, the QS method "simplifies the whole instruction method," Dr. Edwards said in an interview. "If their period is 2 weeks later, it requires them to really wait a long time. Maybe she'll forget to start, or maybe in that interim, she'll get pregnant, because she's not on any method." She added that the two clinics in the study could dispense the pills immediately, rather than giving a prescription to be filled.

She conceded the pregnancy rates between groups were not different at either follow-up.

The efficacy of the QS method was echoed by Dr. Margaret Blythe, professor of pediatrics at Riley Hospital for Children in Indianapolis. "We find that kids come into the clinic and get education about it, and often it will be very confusing to them as to really when to start it," she said in an interview. "Or they'll walk out and think, 'Well, I don't really have to get the prescription, because my next period doesn't start for another couple of weeks.' But on the other hand, if you start them that day, there's an immediacy and a need to go ahead and get the prescription filled."

Dr. Blythe said she often gives the first pack. The patient then takes the first pill on site.

"We do the same thing with Depo-Provera, in terms of making sure when their last period was, when their last unprotected sex was—and also, whether they're in need of emergency contraception," she added.

As to why the QS method isn't standard, "I think one of the biggest issues was fear—having an unknown pregnancy and starting a hormone method with unknown effects," Dr. Blythe said. "But the data really support [the idea] that these hormones are safe, even if someone is pregnant." ■

Ovarian Cancer Survival Is Better Under Care of Gyn. Oncologists

BY JANE SALODOF MACNEIL
Senior Editor

SAN DIEGO — A retrospective study of 1,491 Northern Californians diagnosed with ovarian cancer from 1994 to 1996 determined that women with the disease were likely to live significantly longer if treated by a gynecologic oncologist.

Women in the care of these cancer subspecialists had a 5-year survival rate of 39%, Dr. John K. Chan reported at the annual meeting of the Society of Gynecologic Oncologists. Only 30% of women treated by other physicians survived 5 years in the study of patients in the California Cancer Registry.

"Treatment by a gynecologic oncologist is an independent prognostic factor for improved survival," said Dr. Chan, director of gynecologic oncology at the University of California, San Francisco. He worked on the study while a faculty member at Stanford (Calif.) University.

Dr. Chan and his colleagues attributed the survival advantage to gynecologic oncologists doing more primary surgery with appropriate staging and giving more chemotherapy. Nearly all the patients in subspecialist care had primary surgery (92%) and chemotherapy (90%), compared with 69% and 70% of those treated by other physicians. Women who didn't go to a gynecologic oncologist were four times more likely to have unstaged cancers (8% vs. 2%).

"We're just doing the standard treatment—what the guidelines recommend, and what all the national organizations and all the studies prove is efficacious. It is nothing magical," Dr. Chan said in an interview.

He noted that the findings are consistent with smaller studies that have shown better outcomes in patients treated by gynecologic oncologists. Drawing patients from multiple institutions, the new study provides more demographic detail, he said. Investigators augmented registry data with chemotherapy information from a medical record review and a physician survey.

Despite the extensive literature favoring treatment by gynecologic oncologists, two-thirds of the patients were treated by "others," a group that was not broken down but is presumed to include general surgeons and ob.gyns. Though the proportion of patients receiving subspecialist care increased from 28% to 36% during the period studied, it was still only 34% overall.

Compared with the larger group of women treated by other physicians, the women in the care of gynecologic oncologists were more affluent, more educated, and more often from urban areas. Poorer patients, especially from rural areas, were less likely to see a gynecologic oncologist.

Looking for factors associated with suboptimal treatment of higher-risk, early-stage cancers, the researchers found 21% of younger patients (up to age 55) with stage IC-II cancers did not receive chemotherapy; and only 39% of poorer patients and 38% of patients with early-grade tumors received chemotherapy

"Younger patients who did not receive appropriate treatment were more likely to be classified as poor, less likely to be treated by a gynecologic oncologist, and had more early-grade cancers," Dr. Chan said. ■