Monophasic OCs Said to Ease Menstrual Migraines

BY NANCY A. MELVILLE
Contributing Writer

SCOTTSDALE, ARIZ. — Because fluctuating hormones are believed to be the key culprit behind menstrual migraines, low-dose monophasic oral contraceptives are generally the best alternative to help such patients, Christine Lay, M.D., said at a symposium sponsored by the American Headache Society.

Ob.gyns. often turn to biphasic contraception instead of monophasic pills in the belief that varying the hormone dosage will help alleviate menstrual migraines, but the dosage schedule can make the problem worse, said Dr. Lay, a neurologist with the Headache Institute at Roosevelt Hospital, New York.

Dr. Lay gave the example of Mircette, which contains 21 days of 0.15-mg desogestrel/0.02-mg ethinyl estradiol, followed by 2 days of placebo pills and 5 days of 0.01-mg ethinyl estradiol. "I have numerous ob.gyns. who put patients on Mircette because they think it might help menstrually-related migraines," she said.

Instead, the method introduces another level of fluctuation of estrogen, and it is that fluctuation that is believed to trigger the migraines in the first place, said Dr. Lay

Even worse for menstrual migraines are triphasic pills, which cause greater fluctuation in hormone levels and often are high-dose pills, said Dr. Lay.

"The triphasic pills are the worst for migraine patients," she said. "Invariably, you will have a patient track her calendar and over a month's period of time she will report that within a day or two of switching to a new dose of pill, the woman will experience a migraine attack."

Migraine patients generally fare much better when using monophasic low-dose (20-mcg) birth control pills, which offer a more uniform hormone level, Dr. Lay said, adding that the estrogen patch is another effective way of providing a more steady level of estrogen. Newer noncycling methods such as Seasonale (ethinyl estradiol and levonorgestrel) are also good alternatives for migraineurs, she said in an interview

Estrogen use in patients who suffered from migraines was frowned upon for many years, but the International Headache Society Task Force on Combined Oral Contraceptives and HRT determined more recently that it was safe for migraineurs, provided that there are no other risk factors for coronary heart disease or vascular disease.

In addition, the migraine should be without aura and patients should be given the lowest effective hormone dose.

In the ebb and flow of hormone levels, it is the withdrawal of estrogen, specifically, that experts believe contributes to menstrual migraines. The withdrawal is believed not only to affect trigeminal pain pathways and have vasculature effects, but it may modulate neurotransmitters and magnesium, Dr. Lay said at the meeting.

The release of prostaglandin also plays a role in migraines, sensitizing peripheral nociceptors to pain and mediating hyperalgesia, and prostaglandin is known to increase during migraine attacks.

A key approach to treatment is having patients maintain a diary in which they track their menses and headache days, Dr. Lay said. The journal can help guide treatment options and determine the role of oral contraceptive use.

Since menstrual migraines can occur in young, otherwise healthy women, Dr. Lay strongly recommended using caution in approaching contraceptive issues.

"This is a critical time to discuss with patients pregnancy planning and medication contraindications in pregnancy because, invariably, some of these patients could wind up getting pregnant" unintentionally. "We recommend taking a patient off the pill when efforts to prevent migraines are unsuccessful," Dr. Lay added.

"Physicians may have the patient go off the pill in order to observe the migraine pattern over time. However, the migraine pattern may not improve for at least 3-6 months. In such cases, it's essential to talk about pregnancy issues if the patient is on the pill for contraceptive purposes."

Short-term prophylaxis approaches recommended to prevent the onset of menstrual migraines range from NSAIDs to triptans, and for a more long-term prevention, Dr. Lay suggested considering standard preventive medications, including tricyclic antidepressant, antiepileptic drugs, β-blockers, and selective serotonin reuptake inhibitors. ■

Study: Parental Notification Laws May Lead to More Teen Pregnancies

BY MARY ELLEN SCHNEIDER
Senior Writer

Laws that require parental notification for teens to receive prescription contraception at family planning clinics could increase the risk of teen pregnancy, according to a study by Rachel Jones, Ph.D., and her colleagues.

"Family planning clinics need to be supported in the work that they are doing with teens," said Dr. Jones, senior research associate at the Alan Guttmacher Institute (JAMA 2005;293:340-8).

The study found that if a law required clinics to inform parents in writing when their teenagers got prescription birth control, 18% of teens would have sex using no contraceptive method or would rely on rhythm or withdrawal.

About 1% of teens surveyed said their only reaction to such a law would be to stop having sex, the study said.

Most teens said they would continue to use the services at the clinic even if parental notification was required or would use over-the-counter contraceptives, such as condoms.

The implications are that mandated parental notification laws would discourage few teens from having sex and likely would increase rates of adolescent pregnancy and sexually transmitted diseases, the study authors concluded.

The study was based on a nationwide survey of 1,526 adolescent females under age 18 years who were seeking sexual health services, excluding abortion and prenatal and postnatal care, at publicly funded family planning clinics in 33 states.

About 60% of respondents said their parents were aware that they were using a clinic for sexual health services. In most cases, the teens had either voluntarily told their parents or they had come to the clinic at the suggestion of a parent.

About one-third of teens surveyed said their parent or guardian was unaware that they were obtaining sexual health services at the clinic. About 4% said they were unsure if their parents knew.

Reasons respondents gave for not informing their parents include:

- ▶ Not wanting parents to know of the teen's sexual activity.
- ▶ Not wanting parents to be disappointed by the teen's sexual activity.
- ▶ Not feeling comfortable with discussing sex with their parents.
- ▶ Not wanting parents to know the reason for the teen's clinic visit.
- ▶ Wanting to take responsibility for their own health.

Concerned Women for America (CWA), a group that supports abstinence-only education, discounted the study. CWA said the study is biased because its authors are researchers associated with the Alan Guttmacher Institute, which is affiliated with Planned Parenthood. CWA claims that Planned Parenthood is concerned that greater parental involvement will mean less business for them.

"Policymakers need to stop treating parents as a suspect class, presumed not to have their own kids' best interests at heart," Wendy Wright, CWA's senior policy director, said in a statement. "Adolescents benefit when their parents are involved in their lives, and policymakers shouldn't forbid their involvement in their daughters' and sons' most important decisions."

Texas and Utah currently require parental consent for teenage use of state-funded family planning services, and a similar restriction exists in one county in Illinois. Last year, lawmakers in Kentucky, Minnesota, and Virginia introduced bills to impose parental consent requirements on teens seeking contraception.

On the federal level, lawmakers have introduced plans in recent years to require parental involvement in teens seeking contraceptives at federally funded clinics; none has become law. ■

Consider Discontinuation of Hormonal Contraceptives to Reverse Sexual Dysfunction

BY KATE JOHNSON
Montreal Bureau

PHILADELPHIA — Discontinuation of hormonal contraceptives should be the first-line approach in addressing sexual dysfunction in women using these agents. Susan Sarajari, M.D., outlined her study of 20 women who experienced improved sexual function after discontinuing hormonal contraception.

"This is the first trial that correlates serum androgen changes with specific domains of sexual function," she said at the annual meeting of the American Society for Reproductive Medicine.

About 15% of hormonal contraceptive users report sexual dysfunction in the form of low libido, vaginal dryness, impaired orgasm, and decreased arousal. "This may be the result of changes in serum androgens," said Dr. Sarajari, a fellow in reproductive endocrinology and infertility at the University of California, Los Angeles, Medical Center.

Her study measured baseline total testosterone, free testosterone, and sex hormone–binding globulin (SHBG) in premenopausal women (mean age 34) who had been using hormonal contraceptives for at least 6 months. Most women had been taking oral contraceptives, but one had been using a contraceptive patch and one had been using a contraceptive vaginal ring.

The serum levels were assessed again 4 months after the women discontinued using contraception. Patients also completed questionnaires at baseline and at the end of the study, which assessed sexual function, related distress, and sexual desire and energy.

Mean total and free testosterone levels increased, while SHBG rose significantly after contraceptive discontinuation. These changes coincided with an increase in sexual energy, decrease in sexual distress, and an improvement in global sexual function scores.

"There was significant improvement in arousal, lubrication, orgasm, and satisfaction," she said, noting that the "antiandrogenic" profiles of hormonal contraceptives that are promoted by drug companies are not entirely beneficial.

But she says the fact that sexual dysfunction can be reversed with discontinuation of hormonal contraceptives is encouraging.

"We don't recommend testosterone supplementation ad lib, or at all, until the cause of someone's sexual dysfunction is investigated, Dr. Sarajari said. ■