

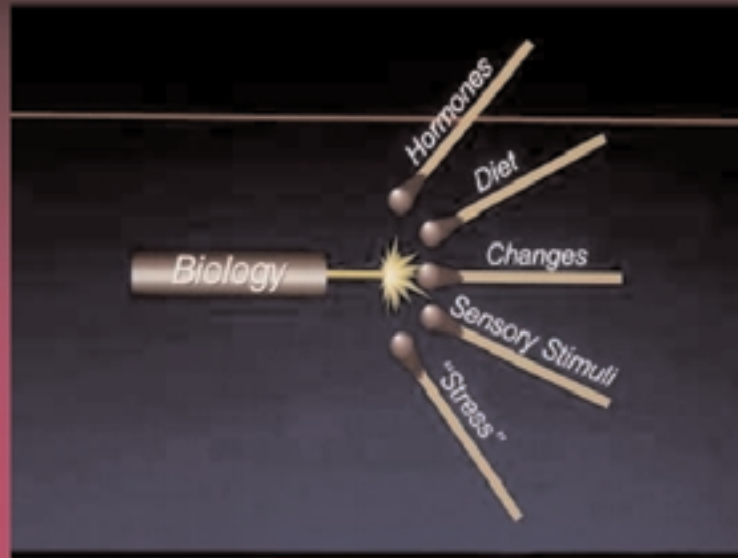
Menstrual Migraine (MM)



- **Definitions:** true MM—attacks occur only perimenstrually; menstrually related migraine—attacks predictably associated with perimenstrual days but may occur at other times.
- **Characteristics:** usually migraine without aura; may be of increased severity but usually not increased resistance to treatment.
- **Significance:** predictable onset allows prophylaxis by short course of anti-migraine medication.

Women with migraine will commonly report increased vulnerability to headache at the time of their menses, from 2 days before onset to day 3 of menses. The long-standing clinical impression that menstrually related migraines are more severe has been dispelled by a recent study reporting that features of menstrually related attacks did not differ significantly from attacks occurring at other times of the month. (Stewart WF, Lipton RB, Chee E, et al. Menstrual cycle and headache in a population sample of migraineurs. *Neurology* 2000;55:1517-1523.) The clinical significance is rather in the opportunity to offer prophylactic treatment to women whose attacks are strongly associated with a predictable onset of menses.

Patients may overestimate or underestimate the strength of the association between their menstrual cycle and migraine attacks. Thus, it is necessary to have at least 3 months of headache calendar information before instituting prophylactic treatment, such as a short course of an NSAID or triptan for the perimenstrual days. The headache calendar should record: attack severity and duration, medication dosing and efficacy, onset of menses, and any other putative triggers of interest.



Current understanding of migraine biology postulates a hyperexcitable nervous system with episodic fluctuations in sensitivity to irritating stimuli, i.e., triggers. Evidence is stronger to validate some triggers (e.g., hormones) than others (e.g., diet). “Changes” capable of triggering migraine biology can include changing weather patterns, changes in sleep patterns, changes in psychophysiological arousal, and changes in blood sugar levels (skipped meals or fasting/dieting).

It is helpful to explain to patients the episodic nature of the disorder and the fact that some triggers may be tolerated in isolation but not when they coincide. For example, skipping lunch when under pressure at work may trigger an attack in a patient who may tolerate either trigger (fasting or stress) in isolation.

Patients may overestimate the influence of triggers and institute unnecessary and restrictive lifestyle changes—for example, mistaking premenstrual cravings for sugary or salty foods as triggering the menstrual migraine that occurs thereafter. A calendar record of at least 3 months duration is recommended for identifying and validating purported migraine triggers.

Sample Headache Diary



Month of: Name:			
Day	Severity 0 – headache-free 1 – mild headache, allowing normal activity 2 – moderate headache, disturbing but not preventing normal activity 3 – severe headache, normal activity is impossible.	Relief Measures 1. ice pack 2. bed rest 3. dark room 4. medication (name and dosage) 5. relaxation 6. other (specify)	Suspected Triggers 1. menstruation 2. skipped meals 3. excess caffeine 4. stress 5. changed sleep 6. missed medication 7. other (specify)
1			
2			
3			
4			

For online version, courtesy of ACHENET achenet.org/resources/diary.php

A headache calendar should be a simple factual record, not a diary of the patient's experiences. The calendar should be kept on a daily basis, since memory for pain is prone to distortion. The physician can suggest that patients use a month-at-a-glance calendar to jot down headache occurrence, days of menstrual bleeding, and medication dosage and efficacy. Alternatively, a one-page form with instructions for use can be downloaded and printed from the ACHENET.ORG website under the "Resources" link.

In addition to verifying an association with menses, a headache calendar offers several benefits for improving patient-physician interactions:

- The accuracy of the patient's overall report of headache frequency and severity can be assessed.
- Possible medication overuse can be monitored.
- Treatment success or failure can be tracked.
- The patient will understand that follow-up is an important component of the treatment plan, and that if the initial treatment is less than optimal, another therapy can and will be tried.