

# LETTER to the Editor

## To the Editor:

Although we agree that migraine certainly has a hormonal component in women, I disagree with Dr. Lynne O. Geweke's therapeutic conclusions in her article "Menopause and Migraine" in the September/October 2007 issue of *Menopause Management*.<sup>1</sup> Dr. Geweke acknowledges that "some women worsen...and some...develop new-onset migraine...around menopause," and that "oophorectomy appears to be associated with worsening of migraine in a substantial percentage of women..." She also acknowledges that "women prone to migraine may experience...menstrual migraine during the placebo week [of OCPs] when estrogen levels fall..."<sup>1</sup>

Additionally, while I acknowledge and agree with the effectiveness and importance of abortive agents, including triptans, I disagree with her "horse already out of the barn" therapeutic (rather than preventive) approach to migraine therapy, and take issue with her statement that "first-line treatment of hormonally triggered migraines does not involve hormonal manipulation."<sup>1</sup>

I agree with Dr. Geweke's statement that "hormonal changes are...migraine triggers."<sup>1</sup> If we both agree, as it appears we do, that abrupt fluctuation in estrogen levels is a direct migraine trigger<sup>2,3</sup> (whether this is a cyclic fluctuation—as seen in reproductive-age women immediately prior to and during menses—or the irregular fluctuation seen in peri- and newly menopausal women), then disarming the trigger via the preemptive use

of hormone therapy (HT) prior to and during menses for menstrual migraine and as an ongoing therapy in peri- and newly menopausal women is appropriate as a first-line therapeutic approach.<sup>3-14</sup> I do, however, agree that this opinion is certainly not universally shared.<sup>14-16</sup>

Dr. Geweke makes the statement that "...hormonal manipulation is less predictable [than triptans] and may actually worsen migraine in a significant percentage of patients."<sup>1</sup> This runs counter to my experience of significant improvement in both menstrual and perimenopausal migraine with the addition of HT (Goodman MP, unpublished data).

We agree that hormonal changes may be viewed as "potent migraine triggers."<sup>1</sup> It would appear to follow, therefore, that any therapy that normalizes or "smoothes out" these fluctuations would be beneficial. The author admits that migraine is associated with falling estrogen levels; why, then, not admit to the validity of supplemental estrogen administered cyclically, perimenstrually and continually in low-dose percutaneous form during the menopausal transition for migraine prevention?

Dr. Geweke correctly points out that oral HT formulations are associated with wide variations of blood levels of estradiol. She also correctly points out that stress is a trigger for migraine. Certainly, hot flashes, mood

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*Michael Goodman, MD, FACOG*

fluctuations, sleep and memory issues, joint aches and other disturbing symptoms of the menopausal transition are stressors. These stress triggers are ameliorated by hormonal supplementation.

I find my therapeutic approach for menstrual migraine (application of a 0.075-mg or 0.1-mg transdermal patch at the onset of premenstrual symptoms, changing every 3 days until menses end, and then adding one-half patch for 3 additional days to prevent rebound) to be effectively therapeutic (Goodman MP, unpublished data), utilizing analgesics and triptans as a PRN back-up. I also find a low-dose transdermal estradiol product—to smooth out the “valleys” inherent in the menopausal transition—to be helpful both in reducing stressors and, to some extent, headaches.

*Michael Goodman, MD, FACOG*

Caring for Women: A Specialty Women's Healthcare Practice  
Davis, CA

### **Author's Response:**

I appreciate the opportunity to respond to Dr. Goodman's comments. First, I would like to point out that I did not cover, nor intend to cover, the complexities of menstrual migraine. Insofar as I discussed menstrual migraine, it was as background to the role of hormones in migraine as it presents in menopause.

I do find serious flaws in Dr. Goodman's logic, which seems to be that because hormones influence migraines, the best treatment of migraine must necessarily be hormonal. This simply doesn't follow. In medicine, the most direct approach to treatment is almost always the most successful. We treat infections first with antibiotics, hypertension with anti-hypertensive drugs, and diabetes with insulin or oral agents, even when there are concomitant modifying conditions.

I reiterate that we have excellent medications for migraine that are quite disease-specific, especially the triptans, and I submit that this direct approach is by far the most sensible first-line treatment. Multiple studies have reinforced the efficacy and safety of triptans in treating menstrual migraine, and overall efficacy of triptans in aborting migraine attacks is very high. Furthermore, they need be used only intermittently. When prevention is needed, there are several medications, including beta blockers and some anticonvulsants,

that have proven efficacy in double-blind, placebo-controlled trials, and have FDA indications for migraine prevention.

Although hormonally triggered migraines have a reputation of being hard to treat, the vast majority do respond well to these standard migraine treatments. By comparison, evidence for success with hormonal manipulation is much less convincing; most reports are, like Dr. Goodman's experience, anecdotal or deal with very small numbers. So far, there are no studies that show a success rate for hormonal manipulation that remotely approaches that of triptans. Furthermore, hormones must be given for longer periods of time, and have more prolonged systemic effects. The Women's Health Initiative study has taught us that hormone supplementation at menopause is not completely innocuous. And finally, I repeat that in the vast majority of women with migraine, even at menopause, there is nothing abnormal about their hormone levels. We always need to ask ourselves what we are attempting to fix, and why we choose hormones (or any other medication) to fix it.

I would add that my own anecdotal experience in 20 years as a headache specialist has not been remotely as favorable to hormonal manipulation as Dr. Goodman's. We are always influenced by our training (I am board certified in Neurology and Headache Medicine), and we see what we are primed to see. This is why evidence-based reports are so critical. I must agree with Dr. Loder and colleagues who, in their fine review, note that “hormonal treatment of migraine is not a first-line treatment strategy for most women...the harm to benefit balances of several traditional nonhormonal therapies are better established.”<sup>1</sup>

*Lynn O. Geweke, MD*

Clinical Assistant Professor  
Director, Headache Clinic  
Department of Neurology  
University of Iowa  
Iowa City, IA

*The references listed in the letter and the author's response can be found at [www.menopausegmt.com](http://www.menopausegmt.com).*