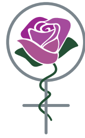

Newson Health

Migraine and Menopause

What is migraine?

A migraine is a moderate or severe headache - often felt as a throbbing pain – and usually occurring on one side of the head. It often comes with nausea or vomiting, and a heightened sensitivity to light or sound. The headache is such that it stops you doing what you normally do and can last from four to 72 hours.

Migraines can occur with or without 'aura'. Aura is the term for a collection of symptoms that occur just before the migraine comes on – this might only be a few minutes before the headache or up to an hour before. Aura usually includes visual disturbances such as seeing dark or coloured spots, flashing lights or zig zag lines, as well as feelings of vertigo (room spinning), dizziness, numbness or tingling. It is most common to get migraines without aura, but for those that do experience aura, it acts as a warning sign that a headache is going to follow. Some people experience the symptoms of aura but then do not feel a headache afterwards, this is sometimes referred to as a 'silent migraine'.

Unfortunately, some people can suffer migraine several times a week, for others it might be every few months, or there may even be years between migraine episodes.

Migraine and hormones

Women are 2-3 times more likely to experience migraines than men. Fluctuating levels of hormones, particularly a dip in estrogen levels, have been found to trigger migraines in some women. In younger women this tends to happen a day or two before a period starts or, for women taking the combined oral contraceptive pill (COCP), this can happen during the week when you stop taking the pill.

In older women migraines can become more common during the perimenopausal and menopausal stages of life when estrogen levels naturally decline.

The pattern of migraine without aura appears to be heavily influenced by a drop in estrogen levels. For this reason, migraine without aura tends to worsen around the perimenopause. Migraine with aura, in contrast, is often associated with higher levels of estrogen; such as when pregnant, if taking the COCP, or when taking Hormone Replacement Therapy (HRT) - as your body is getting used to increased levels of estrogen.

Migraine and the menopause

The occurrence of migraines is most prominent in women in their forties. Hormonal fluctuations become more marked and erratic around the perimenopause - it is very common for migraines (without aura) to worsen at this stage and may coincide with your periods becoming heavier and more erratic. Migraines can also be brought about by other perimenopausal symptoms, such as hot flushes, night sweats, poor sleep and mood swings.

Following a natural menopause, the frequency of migraines generally reduces as the hormonal triggers for headaches settle with time. This may be many years or even decades for some women. If menopause is

bought about by surgery such as a hysterectomy, migraines can initially worsen, but generally settles again after a few years.

Not all migraines are triggered by hormones and therefore you may continue to experience migraine many years after the menopause, even when using hormonal treatments.

Migraine and HRT

HRT can be very effective at alleviating the symptoms of migraine, as well as the associated symptoms of the perimenopause and menopause. Suffering from migraines (with or without aura) does not exclude you from being able to take HRT safely.

HRT replaces the hormones estrogen and progestogen that are naturally declining in your body around the time of the menopause. The safest way to take replacement estrogen (the hormonal trigger for migraine) is through the skin - known as 'transdermal'. Transdermal estrogen comes in patches that stick to your skin (a bit like a plaster), in a gel that you rub into your arms or legs, or in a spray that you spray on your forearm or inner thigh. These transdermal methods of taking estrogen do not increase the risk of a blood clot or stroke occurring.

The estrogen patch, gel or spray should be used continuously, without breaks, so there is a constant release of the hormone straight into your bloodstream - as rapid changes in the level of estrogen can trigger a migraine. It is best practice to start on a low dose of transdermal estrogen and increase very gradually, if your symptoms are not improving.

If you still have your uterus (womb) then you will also need to take a type of progestogen to protect the lining of your womb, as taking estrogen by itself can increase the thickness of the lining of your womb. Taking a progestogen reduces this effect. The progestogen is often given as a tablet (at Newson Health we usually recommend micronised progesterone - Utrogestan), but it can also be given in the form of a coil inserted into the womb (uterus). This is the Mirena® coil, which can be beneficial to those women who also need contraception.

Does anything else help migraine?

A healthy lifestyle can reduce the occurrence of migraine; taking regular exercise, sleeping and eating at regular times, staying well hydrated and limiting caffeine and alcohol can all help. You are also less likely to experience migraine if you are a healthy weight.

Painkillers such as paracetamol and ibuprofen can alleviate the headache pain, and there are other medications specifically for migraines that can be discussed with your GP.

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