

HEADACHE DURING MENOPAUSE AND POST –HYSTERECTOMY

Migraine follows several different pathways during and after the menopause. The headaches often increase in frequency or severity, but at times they may cease altogether. Many women do not experience any change in the migraine pattern. After hysterectomy or oophorectomy, there is also no consistent pattern to the headaches. They may greatly improve after the surgery, but more often the migraines increase.

The confusion surrounding menopausal headaches is increased by the fact that some women improve with estrogen replacement therapy and others experience more headaches. In women placed on estrogens and other cyclic progestins, a moderate or severe increase in migraine should initiate a change in the hormone regimen. At times, it is necessary to discontinue the hormones completely. In women who have not had a hysterectomy, cyclic progestins are necessary, and these are the primary culprit in the exacerbation of the headaches. In addition, the withdrawal of estrogen for a number of days may trigger migraine. In women who have undergone hysterectomy, continuous estrogen therapy for the entire month, without a break, is often the best approach for the headaches.

When choosing an estrogen preparation, the synthetic compounds seem to create less migraine than Premarin. The equine-derived conjugated estrogens (Premarin) are not absorbed at a steady rate, and contain many natural compounds that could possibly trigger headache. Ethinyl estradiol (Estinyl) micronized estradiol (Estrace), esterified estrogens (Estratab), and estropipate (Ogen) are commonly used oral preparations. Estraderm is a transdermal estradiol that delivers a consistent blood level of estrogen. Depo-Estradiol is estradiol cypionate that is injected once every month. Many women will experience less migraine with this once per month injection. The effect of estrogen dose on migraine varies, with some women improving with increased doses, and other experiencing more headaches.

Progestins are utilized primarily to prevent endometrial cancer, increase new bone formation, and prevent osteoporosis. The progestins may exacerbate headache, however. It is helpful to keep the dose to a minimum, and to utilize the progestins for the minimum number of days. However, some women have fewer migraines when on continuous low dose progestins throughout the month.

The addition of androgens (methyltestosterone) may help to alleviate certain symptoms of the menopause. Women often have improved libido, increased feelings of well being, decreased depression, and improvement in headaches while on androgens. Methyltestosterone is occasionally helpful for menstrual and menopausal migraine. The androgens are utilized along with the estrogen, on the same days. Combination preparations are available, such as Estratest tablets, which consist of methyltestosterone (2.5 mg), and esterified estrogens (1.25 mg). Injectable forms are also available. A typical regimen would include one tablet of Estratest from day 1 through 25, and a progestin added from day 13 through 25.