P}{\text{MBChB, DFFP}}
\text{Anne Donegan,}
\text{prescription of combined oral contraception'.}
\text{migraine in the FFPRHC Guidance on ‘First}
\text{Criteria for Contraceptive Use}
\text{1 MacGregor EA. Menstrual migraine: a clinical review.}
\text{2 Faculty of Family Planning and Reproductive Health}
\text{3 Headache Classification Subcommittee of the}
\text{4 Bousser MG, Conard J, Kittner S, de Lignieres B,}
\text{5 MacGregor EA. Hormonal contraception and migraine}
\text{6 Doeges J, Krieger H, Masou V, et al. Prevalence of}
\text{7 Chang C, Donaghy M, Poulter N, and the World Health}
\text{8 MacGregor EA. NICE Guidance on LARC (Letter).}
\text{9 MacGregor EA. NICE Guidance on LARC (Letter).}
\text{10 E Anne MacGregor, MFPP}
\text{Director of Clinical Research, The City of}
\text{Anne Donegan, MBChB, DFFP}
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\text{Health and Reproductive Care, Coventry, UK.}
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\text{References}
\text{1 MacGregor EA. Menstrual migraine: a clinical review.}
\text{2 Faculty of Family Planning and Reproductive Health}
\text{Care (FFPRHC) Clinical Effectiveness Unit. FFPRHC}
\text{UKMEC is trying to distinguish between generalised}
\text{disturbances, which can include ‘flashings’ or flickering}
\text{lights that are normal prodromal symptoms of migraine.}
\text{These occur up to 24 hours before the onset of}
\text{migraine and are not suggestive of focal ischaemia.}
\text{If ‘flashings’ are taken out of this context it is misleading.
UKMEC does state that ‘aura occurs before the onset of}
\text{headache’ but even this needs further clarification. I}
\text{suspect UKMEC is trying to distinguish between}
\text{normal prodromal symptoms of migraine. These}
\text{occur up to 24 hours before the onset of}
\text{headache and can last throughout the attack. They}
\text{are quite different from the specific visual ‘flickerings’
of aura, which start before the onset of headache, last up to an}
\text{hour (usually around 20–30 minutes) and resolve before}
\text{the onset of headache.}
\text{With respect to the FPRHC statement that ‘symptoms of aura include ...
unilateral weakness’, I can confirm that although motor}
\text{weakness is a feature of the rare dominantly}
\text{inherited condition ‘familial hemiplegic migraine’ it is not a feature of
typical migraine with aura. If symptoms in the extremities occur
da during aura, they are sensory, such as pins and}
\text{needles or numbness, often spreading up one}
\text{arm and into the face. Sensory symptoms are also}
\text{important when diagnosing aura. Hence a simple screen for}
\text{migraine with aura:}
\text{Do you have visual disturbances:}
\text{● Starting before headache?}
\text{● Lasting up to one hour?}
\text{● Resolving before the headache?}
\text{If the answer to all three questions is ‘yes’, it is likely that the symptoms are aura.}
\text{Aura can occur without subsequent headache but the}
\text{nature and duration of the aura is unchanged.}
\text{The reason to be concerned about aura is the}
\text{increasing evidence of an increased risk of}
\text{ischaemic stroke which is greater in women with migraine, particularly those using}
\text{combined oral contraceptive pills (CHCs). Fortunately, since stroke is rare}
\text{in young women, the absolute risk is very small.}
\text{I agree with UKMEC’s view that the use of}
\text{CHCs in women with current migraine aura and}
\text{UKMEC 3 for a past history of migraine aura, but}
\text{the question raised is how far in the past a past history of}
\text{aura must be. I have tend to recommend 5 years and}
\text{counsel the woman very carefully to stop CHCs if}
\text{she returns. However, Chang et al’s study}
\text{suggested increased risk of ischaemic stroke in women with migraine aura using}
\text{CHCs with a past history of even just a single attack with}
\text{aura.7 Donaghy et al. showed increased}
\text{risk of ischaemic stroke if initial attacks were}
\text{migraine with aura (OR 8.38, 95% CI 2.33–30.1) suggesting that even a distant past}
\text{history is associated with increased risk.}
\text{As UKMEC recommends, the onset of}
\text{migraine aura during CHC use should remain an absolute contraindication to continuing}
\text{this treatment. I am also a strong advocate for}
\text{for continuing progestogen-only methods. I}
\text{refer to your letter published in the Journal in}
\text{response to the National Institute for Health and}
\text{Clinical Excellence (NICE) guidelines on long}
\text{acting reversible contraception (LARC), in}
\text{which I noted that in contrast to CHCs there is}
\text{evidence that use of progestogen-only methods is}
\text{not associated with increased risk of}
\text{ischaemic stroke.8 Hence, there is no reason}
\text{why these methods should not be continued if}
\text{appropriate methods of contraception.}
\text{Our role is to help women choose safe and}
\text{effective contraception. It has been stated that}
\text{combined oral contraceptive products may lead women to}
\text{use them less than effectively or not at all.9}
\text{Contraception Guidelines for young women are justifiable since there is evidence of risk and}
\text{contraceptive efficacy need not be compromised, as other methods are equally, if not}
\text{more effective. However, if these methods are}
\text{progestogen-only, it would be inappropriate to}
\text{restrict these in the absence of evidence of}
\text{harm.}
\text{In my earlier letter, I recommended that both}
\text{NICE and the World Health Organization should}
\text{consider migraine aura to be Category 2 for both}
\text{initiation and continuation of all}
\text{progestogen-only methods. I request that the}
\text{Faculty of Family Planning and Reproductive Health}
\text{Care also considers this recommendation.}
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\text{London Migraine Clinic, London, UK.}
\text{E-mail: anne.macgregor@sinogram.co.uk}
\text{References}
\text{1 Faculty of Family Planning and Reproductive Health}
\text{Care (FFPRHC) Clinical Effectiveness Unit. FFPRHC}
\text{Guidance (July 2006). First Prescription of Combined}
\text{Oral Contraceptive Guidance (July 2006).}
\text{http://www.ffprhc.org.uk/admin/uploads/298_UKMEC_}
\text{50056.pdf [Accessed 2 February 2007].}
\text{2 Faculty of Family Planning and Reproductive Health}
\text{Care (FFPRHC) Clinical Effectiveness Unit. FFPRHC}
\text{Guidance (July 2006). First Prescription of Combined}
\text{Oral Contraceptive Guidance (July 2006).}
\text{http://www.ffprhc.org.uk/admin/uploads/298_UKMEC_}
\text{50056.pdf [Accessed 2 February 2007].}
\text{3 Headache Classification Subcommittee of the}
\text{International Headache Society (IHS). The}
\text{International Classification of Headache Disorders}
\text{4 Bousser MG, Conard J, Kittner S, de Lignieres B,}
\text{MacGregor EA, Massou H, et al. Recommendations on}
\text{the risk of ischaemic stroke associated with use of}
\text{combined oral contraceptives and hormone replacement therapy in women with}
\text{migraine. Cephalalgia 2000; 20: 155–160.}
\text{5 MacGregor EA. Hormonal contraception and migraine}
\text{(FACT Review). J Fam Plann Reprod Health Care}
\text{2001; 27: 49–52.}
\text{6 Gorini M, Urich V, Olesen J, Russell M. Screening for}
\text{migraine in general population: validation of a}
\text{simple questionnaire. Cephalalgia 1998; 18: 342–348.}
\text{Chang C, Donaghy M, Poulier N. World Health}
\text{Organization Collaboration Study of Cardiovascular}
\text{Disease and Steroid Hormone Contraception. Migraine}
\text{and stroke in young women: cause-control study.}
\text{BMJ 1999; 318: 13–18.}
\text{8 Donaghy M, Chang CL, Poulier N, on behalf of the}
\text{European Collaborators of the World Health}
\text{Organization Collaborative Study of Cardiovascular}
\text{Disease and Steroid Hormone Contraception. Outcomes frequency, course and risk of}
\text{ischaemic stroke in women of childbearing age.}
\text{J Neurol Neurosurg Psychiatry 2002; 73: 747–750.}
\text{9 MacGregor EA. NICE Guidance on LARC (Letter).}
\text{J Fam Plann Reprod Health Care 2006; 32: 52.}
\text{10 Clapham J, Miller L, Pronay P, et al. Use of}
\text{hormonal contraceptives. J Womens Health (Larchmt)}
\text{2008; 14: 53–60.}