Conflicting terminology in the context of migraine

Having read the January 2007 issue of the Journal with the very interesting and well-written article on menstrual migraine by Anne MacGregor, I was surprised by the words "flickering lights" (Box 1: 1.2.1 Typical aura with migraine headaches B.1) in the context of migraine.

This is confusing as the UK Medical Eligibility Criteria for Contraceptive Use seems to have a different perspective on neurological symptoms. For example, whereas these symptoms are classified as typical of aura: they use the words "flickering lights" and state this is "not a symptom of aura.

We have discussed this matter in our Journal Club and would be grateful if this could be clarified.

In addition to my query I would like to let you know how much I appreciate your Journal. I thoroughly enjoy reading it, and keeping up to date is a pleasure with your excellent Journal. In addition to my current study for my MFFP Part 2 and feel it is very helpful! I wouldn’t want to be without it.

Thanks for all the daily hard work you put into developing the area of Contraception and Sexual Health. It is much appreciated.

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References

Menstrual migraine

Thank you for the excellent article on menstrual migraine. I note some discrepancies between the International Headache Society classification of migraine in the article and information on migraine in the FFPRHC Guidance on ‘First Eligibility Criteria for Contraceptive Use (UKMEC)’ (2005/2006). Generalised ‘spots before the eyes’, ‘flickering lights’, blurring of vision, or photophobia of variable duration before or without headache occur during migraine and are not suggestive of focal ischaemia.

If ‘flickering lights’ are taken out of this context it is misleading. UKMEC does state that “aura occurs before the onset of headache” but even this needs further clarification. I suspect UKMEC is trying to distinguish between generalised visual disturbances, which can include ‘flashing’ or flickering lights that are normal prodromal symptoms of migraine. These occur up to 24 hours before the onset of headache and can last throughout the attack. They are quite different from the specific visual ‘flickerings’ of aura, which start before the onset of headache, last up to an hour (usually around 20–30 minutes) and resolve before the onset of headache.

With respect to the FFPRHC statement that “symptoms of aura include … unilateral weakness”, I can confirm that although motor weakness is a feature of the rarely predominantly inherited condition ‘familial hemiplegic migraine’ it is not a feature of typical migraine with aura. If symptoms in the extremities occur during aura, they are sensory, such as pins and needles or numbness, often spreading up one arm and into the face. Sensory symptoms are almost always associated with visual symptoms. Hence a simple screen for migraine with aura is:

Do you have visual disturbances:

- Starting before the headache?
- Lasting up to one hour?
- Resolving before the headache?

If the answer to all three questions is ‘yes’, it is likely the symptoms are aura.8 Aura can occur without subsequent headache but the nature and duration of the aura is unchanged.

The reason to be concerned about aura is the increasing body of evidence of an increased risk of ischaemic stroke which is greater in women with migraine aura, particularly those using combined oral contraceptives (CHCs). Fortunately, since stroke is rare in young women, the absolute risk is very small. I agree with UKMEC’s recommendation for CHC use in women with current migraine aura and UKMEC 3 for a past history of migraine aura, although the question raised is how far in the past is a past history? A pragmatic basis at have tended to recommend 5 years and I counsel the woman very carefully to stop CHCs if aura returns. However, Chang et al.’s study suggested increased risk of ischaemic stroke in women with migraine with aura using CHCs with a past history of even just a single attack with aura.9 Donaghy et al. showed increased risk of ischaemic stroke if initial attacks were migraine with aura (OR 8.38, 95% CI 2.33–30.1) suggesting that even a distant past history is associated with increased risk.

As UKMEC recommends that the use of migraine aura during CHC use should remain an absolute contraindication to continuing this method of contraception I am grateful to Drs Ischebeck and Donegan for their letter published in the Journal in response to the National Institute for Health and Clinical Excellence (NICE) guidelines on long-acting reversible contraception (LARC), in which I noted that in contrast to CHCs there is evidence that use of progestogen-only methods is not associated with increased risk of ischaemic stroke.5 Hence, there is no reason why these methods should not be continued if appropriate methods of contraception.

Our role is to help women choose safe and effective contraception. It has been said that “contraceptive products may lead women to use them less than effectively or not at all.”10 Considering Contraception and Sexual Health is justifiable since there is evidence of risk and contraceptive efficacy need not be compromised, as other methods are equally, if not more, effective. If CHCs are the preferred method these are progestogen-only methods, it would be inappropriate to restrict these in the absence of evidence of harm. In my earlier letter, I recommended that both NICE and the World Health Organization should consider migraine aura to be Category 2 for both initiation and continuation of all progesterone-only methods. I request that the Faculty of Family Planning and Reproductive Health Care also considers this recommendation.

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References