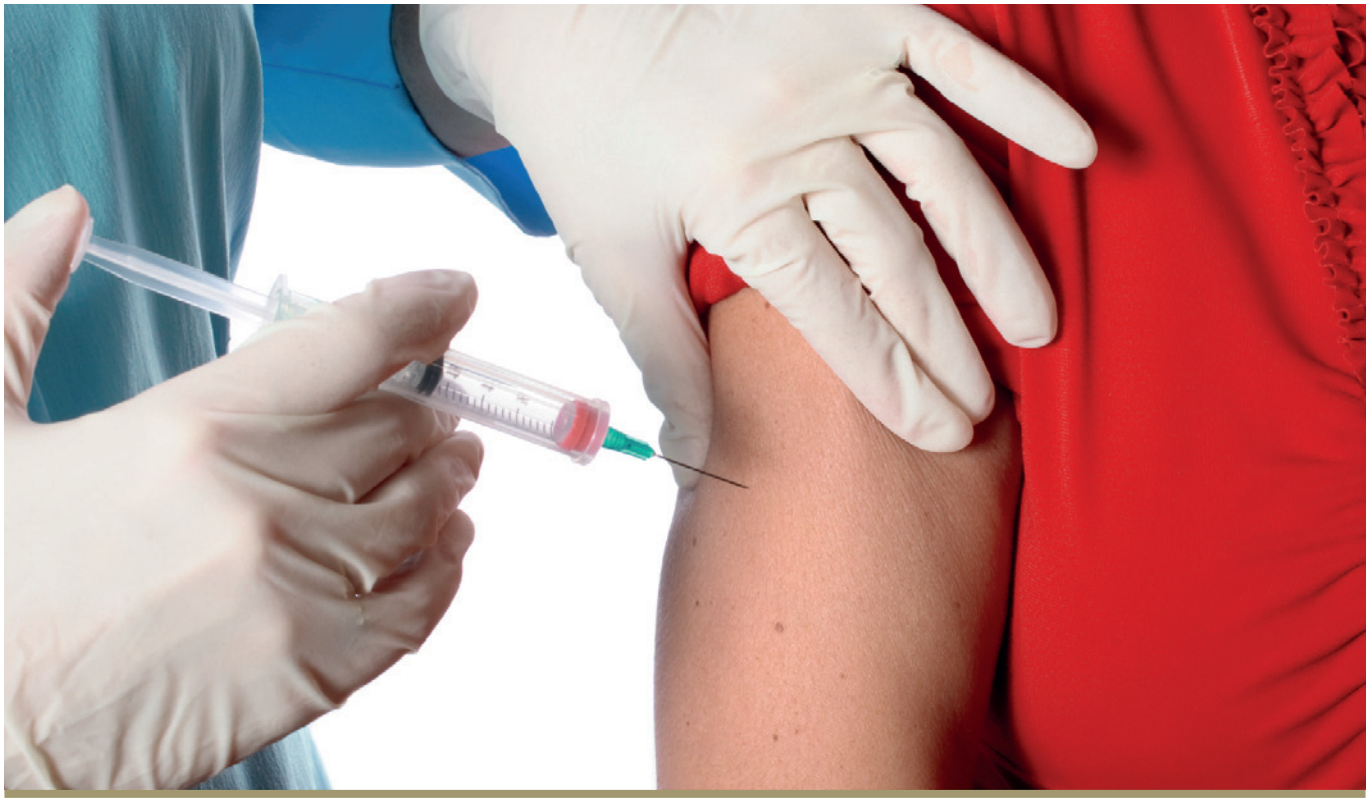

Case study: LARC for younger patients with migraine

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Introduction
Contraception should be reliable and safe, but some short acting methods are neither of these for certain women and LARC, or longer acting reversible contraceptive, methods may be a more suitable options for these patients.

Contraception choices
The most common contraceptive choices in Ireland are condoms, the combined hormone pill or both. Unfortunately these methods require a lot of compliance and so are far from foolproof. As younger women are at the peak of their fertility, and are often using these methods of contraception, the net result of these factors means young women using the pill are much more likely to experience an unplanned pregnancy. One forgotten pill; particularly near the pill-free interval, may result in an unintended pregnancy. The reliability data tables demonstrate this. The pill has a failure rate of less than one pregnancy per hundred women for each year of use when used perfectly, but the real failure rate is closer to eight pregnancies per hundred women per year of use. Additionally, we know not using a condom, or putting it on incorrectly, is more common in young or recently sexually active couples.

For these reasons, nurses and GPs are being encouraged to mention longer acting reversible contraceptive methods or LARC to the younger, more vulnerable patients. LARCs prevent pregnancies much more reliably than pills and condoms, as they do not require the user to do anything at the time of sex. The medication or product is in place keeping them safe by default. If a young woman is informed about the LARC options when she attends for a repeat pill visit, it may be possible to help reduce her potential for an unplanned pregnancy in the future.

Remember though, concordance is key for compliance and continuation, so it is up to us to be knowledgeable so that we can clearly explain the details of all the LARC options and then support the patient's choice.

Another important aspect of LARC options is that none of them are known to be associated with thrombo embolic complication and so can be offered to women who have restriction to use of the combined pills, patch and ring.

LARC products include: Depo-Provera intramuscular injection, copper Intrauterine devices, the Mirena and Jaydess Intrauterine devices and the Implanon NXT implant.

Case Study
A 19-year-old lady presents to the practice asking for a prescription for the combined pill. In the course of taking her past medical history, she reports suffering from migraine headache. On enquiry she describes the nature of the headaches; they

started happening a few years ago when she was studying for her Leaving Certificate exam. They occur every two or three months on average and the pain is usually one sided. The headache can be accompanied by spots across both fields of vision and some light sensitivity and she sometimes feels nauseated. They may last several hours and are usually eased, but not relieved by paracetamol. She occasionally needs to leave work if they are severe.

Discussion

Headache and contraception choices

What questions do you need to ask her at this point?

The key to managing this patient is to ascertain if these are in fact migraine headaches that she is describing and if so which type of migraine are they?

Migraine is a complex condition with a wide variety of symptoms. About one-in-10 of the population complain of migraine and most sufferers, but not all describe a painful headache as the main feature. Other symptoms may include disturbed vision, sensitivity to light, sound and smells, feeling sick and vomiting. The attacks can last for several hours or days. They are more common in women, usually start in childhood or adolescence and are most prevalent in young adults and middle-aged people. Only about 50 per cent of sufferers consult their GP for care. GPs only diagnose migraine correctly in about 50 per cent of presenting sufferers and many patients are provided with therapies that they find ineffective. Many sufferers rely on OTC medications, which may not work.

Currently, there are no consistent guidelines for the diagnosis and management of migraine and other headaches in primary care. There are guidelines available to GPs, but some of these guidelines do not agree on basic principles so diagnosis is still difficult. No single headache feature and no single non-headache symptom are absolutely required for diagnosis of migraine. For example, a patient with severe bilateral headache associated with photophobia and phonophobia can be diagnosed with migraine, just as the more typical patient with unilateral, throbbing headache that is worsened by activity and accompanied with nausea.

Migraine diagnosis requires a flexible approach rather than the simple 'ticking of boxes'.

Good headache questions include:

1. What is the impact of the headache on the sufferer's daily life? (high impact = migraine or chronic daily headache; low impact = acute tension-type headache).
2. How many days of headache does the patient have every month? (> 15 days = chronic headache; ≤ 15 days = intermittent migraine).
3. For patients with chronic daily headache, on how may days per week does the patient take painkillers ? (≥ 2 = analgesic-dependent headache; < 2 = non- analgesic-dependent headache).
4. For patients with migraine, does the patient experience reversible sensory symptoms associated with their attacks? (yes = migraine with aura; no = migraine without aura).
5. Has the pattern of the headache changed over the last six months? (This is designed to alert the healthcare professional to sinister headache conditions; a new or different headache requires a thorough diagnostic approach, while a stable headache pattern provides reassurance to the doctor and patient).

Migraine with aura

Migraine with aura is defined as migraine headache that is associated with one or more fully reversible neurological symptoms. These symptoms typically include: scintillation scotomas (such as a bright rim around an area of visual loss (fortification spectra), jagged lines that block the visual field, visual resizing or reshaping of objects, blurred vision, unilateral sensory parasthesia, eg, numbness in the hand which may migrate up the arm before moving into the face, lips and tongue, muscular weakness, partial paralysis on one side of the body and temporary dysphasia. The UK Faculty of Reproductive and Sexual Health specify that flashing lights across both eyes does not qualify as neurological aura.

One or more aura symptoms develop gradually over more than four minutes, or two or more symptoms occur in succession. In general no single aura symptom lasts more than 60 minutes and the migraine headache occurs less than 60 minutes after the end of the aura symptoms.

Remember though secondary (sinister) headaches have to be excluded as the cause of the aura symptoms.

Plan of action

After careful discussion, it is confirmed that while this young woman does indeed suffer from migraine there are no features to suggest migraine with aura. She has a normal BMI and is a non-smoker. She has no other TE risks and as such she may be prescribed an oestrogen containing pill, patch or ring as migraine without aura is only UKMEC Category 2 (benefits outweigh risks) for these methods. She agrees to start a three-month trial prescription for a 30 microgram Levonorgestrel pill (Ovranette or Ovreena).

Follow up with patient

When the patient returns after three months she mentions that she has had more frequent migraine since going on the pill and can occasionally get one sided visual disturbances (homonymous hemianopia) before the headache begins. This is now a diagnosis of migraine with aura and so the patient must be advised to discontinue the pill and consider one of the LARC options. Migraine with aura is UKMEC 1 for the copper coil and UKMEC 2 for all other LARC options.

Conclusion

Remember, contraception should be reliable and safe for patients. In addition the more convenient a product is to use the more attractive it is for the patient. Some women should not be offered oestrogen methods at all or should be warned to stop using them if their medical history changes. Most women with migraine may be offered any of the LARC methods instead of or as an alternative to the combined oestrogen and progestogen pills, patch, or ring.

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