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Menstrual Migraine is Not at Variance from Classic Migraine Regarding Triggers, Symptoms, Management, and Outcome

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LETTER TO THE EDITOR

We were interested to read the article by Rami, *et al*. on the clinical presentation, triggers, treatment and consequences of menstrual migraine, which is divided into menstrual-only migraine (PMM) and menstrual-associated migraine (MAM) [Mani, T. *et al*., 2025]. It has been found that women tend to have more severe and longer-lasting migraine attacks and that some migraine attacks are related to the menstrual cycle [Mani, T. *et al*., 2025]. Overall, menstrual migraine occurs in 7.6% of women with migraine, and 22% of women with menstrual migraine have the attacks during 50% of menstrual cycles [Mani, T. *et al*., 2025]. Treatment of menstrual migraine includes analgesics, lifestyle adjustments, alternative therapies, avoidance of triggers and prophylactic therapy [Mani, T. *et al*., 2025]. The review is noteworthy, but some points should be discussed.

The first point is that migraine can be triggered not only by reserpine or drugs that act as vasodilators, but also by nitroglycerin, antidepressants or hormone substitution. Headaches in general can also be triggered by epoprostenol, gelcaprevir, pibrentesvir, velpatasvir, alemtuzumab, sofosbuvir, macitentan, treprostinil, abaloparatide, apremilast, omalizumab, ambrisentan, fingolimod, fingolimoid, levothyroxin, tocilizumab, tofacitinib, hydroxychloroquine, erenumab, infliximab, rituximab, certolizumab, pregabalinumab, adalimumab, etanercept, securinumab, evocumab and valsartan and valsartan, so they should be given with caution in migraineurs. Knowing the relationship between medication and migraine is crucial, as attacks can easily be prevented by avoiding the triggering medications.

The second point is that there is no convincing evidence that altitude sickness actually triggers migraines. It is known that people without acclimatisation can experience altitude sickness, which mainly manifests with headaches, and that altitude cerebral edema (HACE) can manifest with severe headaches, but there are no studies showing a clear pathophysiological link between high altitude and migraine. Altitude related headaches can have features of migraines, but classic migraines are not triggered by altitude sickness. Conversely, a history of migraine appears to be a risk factor for developing altitude pain [Davis, C. *et al*., 2016].

The third point is that the topic of migraine stroke was not addressed in the review [Mani, T. *et al*., 2025]. It is well documented that migraine is associated with an increased risk of ischemic stroke. This risk may be increased in patients with additional risk factors for ischemic stroke, such as high blood pressure, smoking, diabetes, hyperlipidemia and atrial fibrillation. Therefore, migraine patients should also minimize their classic cardiovascular risk factors. In addition, it is suspected that menstruation is associated with increased risk of ischemic stroke in general [Seitz, A. *et al*., 2025]. Contraceptives are also known to increase the risk of stroke, especially in combination with classic risk factors for stroke.

The fourth point is that the review only marginally mentions monoclonal CGRP antibodies (gepants) as currently the most effective prophylaxis of migraine. Four of these drugs are currently available -- erenumab, galcanezumab, fremanezumab and eptinezumab. Three of them bind to CGRP (galcanezumab, fremanezumab, eptinezumab) and one to the CGRP receptor (erenumab) [Caronna, E]. Gepants are small molecules (peptides) that antagonize the CGRP receptor and act as vasodilators and are involved in pain processing [Caronna, E . *et al*., 2024].

Fifth, certain subtypes of migraine were not been discussed in the study. These include migraine accopagnee, when the attack is complicated by neurological symptoms such as weakness or sensory disturbances, vestibular migraine, which is accompanied by dizziness, and abdominal

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migraine, which is characterized by abdominal pain, nausea and vomiting and occurs predominantly in children [Angus-Leppan, H. *et al*., 2018].

In summary, this interesting study has limitations that put the results and their interpretation into perspective. Addressing these limitations could reinforce the conclusions and support the study's message. Menstrual migraine is not different from classic migraine in terms of triggers, symptoms, management and outcome.

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