Primary headaches, namely migraine, are a major health concern for women during reproductive life. Medical literature has linked gender to migraine, not only because its predominance in women from puberty to menopause but also because both neuroendocrine events linked to reproductive stages and hormonal interventions, such as oral contraception and replacement therapy, may cause a deep change in the clinical pattern of migraine itself. Several population-based epidemiological studies reported a peak of migraine prevalence in women around 40-50 years and a sharp decrease thereafter. Natural menopause contributes to the improvement of migraine but a significant proportion of postmenopausal women still suffer of such invalidating disease. Surgical menopause seems to be associated with a less favorable course of migraine. While it is very common in clinical practice to observe a benefit from hormone replacement therapy (HRT) when women are in the perimenopausal period because the treatment prevents erratic hormonal secretion, several regimens of oral EPT worsen the clinical picture of migraine when menopause is already well established. Indeed, greater use of anti-migraine preparations by estrogen users than by nonusers were reported and a recent cross-sectional study found that current HRT use was associated with higher rates of migraine headache than nonuse. Transdermal EPT does not seem to have a negative effect either on migraine, even though the cyclic administration of progestins, which is mandatory in non hysterectomized women, may induce migraine attacks. In these cases, a combined low dose EP continuous therapy by using progestins with low androgenic properties or natural progesterone is suggested and several lines of evidence support that migraine without aura is not a contraindication for HRT. Since migraine with aura is a risk factor for stroke and there is evidence for an association between high estrogen states and attacks of migraine with aura, clinical data suggest more caution in the use of HRT. Recently, tibolone, a unique version of HRT, was studied in postmenopausal women referring to tertiary care for severe migraine because such tissue-selective steroid with estrogenic, progestogenic and androgenic properties, seemed to offer some advantages for the treatment of climacteric syndrome in women with “hormone sensitive” headache. It was observed that in postmenopausal headache sufferers treated with tibolone analgesics were more effective in extinguishing severe head pain. These data are extremely interesting in light of the rate of analgesic overuse in long-term migraine sufferers at menopause and beyond. In conclusion, decision-making about HRT in women with migraine may require a careful assessment in term of route, scheme of treatment, dose and biochemical nature of hormonal compounds. In highly symptomatic climacteric women with severe forms of headache HRT may represent a useful tool to improve women’s ability to cope with chronic head pain.

1. Which regimen of HRT has been proven to be more suitable in migraine sufferers at menopause?
   a. Continuous sequential EP treatment
   b. Continuous combined EP treatment
   c. Oral estrogens plus oral progestogens
   d. EP but administered intravaginally
   e. None of the above

2. Which is the most relevant effect of tibolone in severe postmenopausal migraine sufferers?
   a. It cannot be used
   b. It reduces the number of analgesics
   c. It induces aura
   d. It gives more unpredictable bleeding
   e. It increases the number of hours in which pain intensity impairs daily activities

3. The prevalence of migraine at menopause…?
   a. Decreases if women are hysterectomized
   b. Is related to climacteric symptomatology
   c. Is similar to pregnancy
   d. Increases
   e. Decreases