a menstrual migraine (MM) compared with patients' usual treatment.

Background MM affects ~50% of female migraineurs and are reportedly more severe, of longer duration, and more resistant to acute treatment than non-MM. Because migraine treatment improves when triptans are administered early in an attack (Cady, 2004), we assessed early triptan treatment of MM.

Design/methods This open-label study had 2 phases; each included 1 menses. In the baseline phase, patients treated headaches with their current therapy. In the subsequent phase, patients treated all headaches at the mild stage (IHS grade 1) with frovatriptan (2.5 mg). Another dose could be administered after 2 hours. The primary endpoint was pain-free response 4 hours postdose in both phases. Adverse events (AEs) were monitored.

Results Patients (N = 153) had a mean ± standard deviation age of 37.6 ± 8.4 years, 13.5 ± 6.8 MMs in the prior year, and a median 11-year migraine history. Most patients were white (88.2%), and 52% were taking a triptan as usual care. The 4-hour pain-free response was greater with frovatriptan (43.2%; 41/95) vs patients' usual care (30.5%; 29/95). More patients improved with frovatriptan (22.1%) than worsened (9.5%; P = 0.029). More patients (42.2%) preferred frovatriptan than previous treatment (34.8%); 22.2% had no preference (P = 0.015). Commonly reported AEs with frovatriptan were fatigue, nausea, upper respiratory tract infection, and paresthesia (1.2% each).

Conclusion Early treatment of MM with frovatriptan improves pain-free response relative to patients' usual care.

Reference

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F109

Effects of oral contraceptives to migraine headache in women

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Objectives Migraine, as a primary headache is often in the young women with reproductive period. Nowadays most women prefer to use hormonal contraception methods. It is known that using these hormone-contained tablets can influence headache course. In our clinical study we assessed the effects of combined oral contraceptives (COC) to migraine in Hungarian women.

Methods Own-made questionnaires were delivered to the patients by mail. Questions referred to menstrual cycle, to features of headache, and to the ways of contraception. One hundred questionnaires were sent out, and 63 were got back.

Results The response rate of the sent-out questionnaires was 63%. Based on data from 63 questionnaires, 14 women did not use COC. From 49 women migraineurs, who used COC, the migraine pain intensity and frequency, the concomitant symptoms and the duration of the migraine attack worsened in 33% (16 cases), did not change in 59% (29 cases), and improved in 4 cases (8%).

Conclusion The response rate of the applied postal written interview was good (63%). In our study the effects of the combined oral contraceptives on the migraine headache were: mostly no change, in one-third of our patients worsening, and only in a few cases improving. Our results supported the findings of other clinical studies.

References

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F110

Acupuncture for migraine prophylaxis: methodological issues

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The objective of these trials were to evaluate the efficacy of acupuncture for migraine prophylaxis as well as to reach a best methodological design to a phase III trial. Subjects with migraine were randomized to the real or sham acupuncture groups in two different trials.

Distinctive treatment approaches were tested as being real acupuncture. In the first one, the individualized treatment was applied. Semi-standardized acupuncture treatment was evaluated in the second trial. All patients were treated with 16 acupuncture sessions in twelve weeks. Post-treatment follow-ups were done for 6-months. Primary endpoints adopted were the percentage of patients with reduction ≥40% (study one) and ≥50% in migraine attacks frequency (studies one and two) and the total of migraine days (study two).

Improvements with statistical significant differences appeared only in the study one. Real acupuncture group was superior to sham group in the second month of the treatment, when the percentage of patients with ≥50% reduction in migraine attack frequency was evaluated (P = 0.021). The reported differences appeared as well, in two secondary endpoints: number of days with migraine per month (P = 0.007) in the second month of the treatment and in the first (P = 0.044) and second (P = 0.004) months of the treatment when the percentage of patients with a ≥40% reduction in migraine attack frequency was measured.

The individualized treatment adopted in the trial one seemed to be the best approach to test acupuncture for migraine prophylaxis.