Migraines at Every Age

Your headache experience will likely change over time. Here's what to expect—and how to adapt your treatment accordingly.

BY ABIGAIL LIBERS

IF YOU'RE A MIGRAINEUR—the incongruously glamorous-sounding term for a person who gets migraines—you know how agonizing these headaches can be: More than 90 percent of sufferers say that when one strikes, they're unable to work or function normally. The pain, which may feel like throbbing or pulsing, can be accompanied by other miseries such as nausea, vomiting, and sensitivity to light or sound. When the agony hits, up to 30 percent of people also see an aura, a visual disturbance that may look like black dots, flashes of light, or zigzags, says Merle Diamond, MD, president and managing director of the Diamond Headache Clinic in Chicago and a board member of the National Headache Foundation. The torment can last from a few hours to several days.

Migraine has historically been difficult to diagnose and treat because it's been something of an enigma. In part, the lack of knowledge can be attributed to the fact that the condition is more common in women, who are more than twice as likely as men to suffer from it. "Migraine has carried the stigma of being a 'women's disease,'" says Diamond. "It was equated with an inability to cope. Doctors would tell patients, 'Just stop worrying so much and you'll be okay.'"

Today migraine is understood to be a neurological disorder in which overactive nerve cells trigger the release of substances that send pain signals to the brain. Unfortunately, doctors don't know exactly why those nerve cells act up—but whatever the cause, it's hereditary. "Migraine is a genetically inherited vulnerability for networks in the brain to become dysfunctional, usually in response to changes in your external or internal environment," says David Dodick, MD, a professor of neurology at the Mayo Clinic in Phoenix and chair of the American Brain Foundation. External triggers include intense odors (think strong perfume and cigarette smoke) and natural chemicals in foods (such as those in aged cheese, wine, and chocolate); internal triggers can be stress and anxiety, as well as fluctuations in hormones, especially estrogen. And for better or worse, the intensity and frequency change over the years. We've broken down how—and why—migraine may bother us throughout adulthood, and what can be done.

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Migraine often appears for the first time in the teens or early 20s; at least 90 percent of sufferers have their first attack by age 40. Before puberty, boys and girls experience migraine headaches at around the same rate; after puberty, the frequency decreases for boys but can increase dramatically for girls. The reason: period-related estrogen fluctuations. "About 70 percent of women in their 20s and 30s will have migraine attacks around the time of their menstrual cycle," notes Dodick. Another factor, adds Diamond, is that "because estrogen receptors are located in the brain in the vicinity of where migraine is generated, they may mediate some of the pain signals."

The standard treatment for migraine attacks (widely considered the most effective) is targeted drugs called triptans. If you haven't had success with those, Diamond says, an oral contraceptive may be an option to smooth out the monthly hormonal fluctuations that bring the pain.

PREGNANCY

The good news: 70 percent of female migraineurs notice that their head pain disappears during pregnancy. The bad news: Migraines can come back with a vengeance (or even occur for the first time) after you give birth. "You sustain a high level of estrogen throughout pregnancy, and then all of a sudden it plummets," Dodick explains. "That drop can wreak havoc in people with migraine."

If your head pain persists during pregnancy, talk to your doctor. "The lowest-risk treatment is acetaminophen, but certain triptans are also okay," says Diamond. Most triptans are thought to be safe to take after giving birth, but if you're breastfeeding and concerned, Diamond suggests "pumping and dumping" before your baby's next feeding.

AGES 40 TO 49

When you hit your 40s, migraine episodes may initially feel less severe and happen less frequently—until you enter perimenopause and hormones go haywire. "Unlike the predictable monthly fluctuations that occur with your period in your 20s and 30s, hormonal changes during perimenopause become very erratic, which can cause migraines to worsen significantly," says Dodick. "Sometimes the most effective treatment is supplemental estrogen to maintain a steady level." Separately, attacks of a migraine aura *without* the accompanying headache may become more common with age.

AGES 50 TO 59

Once you've entered menopause (the average age of onset in the U.S. is 51), migraine often abates; 55 to 60 percent of women notice an improvement, says Dodick. Unfortunately, those who suffer from chronic migraine (which means more than 15 headache days per month) may not experience much relief.

AGE 60 AND BEYOND

It's rare for migraine to occur for the first time in those older than 60; at this age, severe head pain or other migrainelike symptoms are more likely due to another condition such as stroke. If you're in this age bracket and experience a sudden headache along with nausea, blurred vision, or a droopy eyelid, call your doctor immediately.

Regardless of when and how migraines hit, they can often be managed. The condition is a pain, but it doesn't have to take over your life.

MOVING AHEAD WITH MIGRAINE TREATMENT

For decades, the migraine treatments offered by modern medicine were more an accident of science than the result of targeted research. "Previous preventive medicines were actually designed for conditions like high blood pressure and depression. They just happened to work for migraine, too," says Risa Ravitz, MD, a board-certified neurologist in New York City and founder of the telemedicine start-up Modern Migraine MD. Indeed, the most common strategy for battling chronic migraine was a combination of preventive meds (such as hypertension drugs, antidepressants, antiseizure meds, and Botox injections) and pain-relieving drugs like sumatriptan and rizatriptan. When triptans arrived in the 1990s, they were revolutionary: The first drugs aimed specifically at alleviating migraine, they lead to an increase in serotonin (a neurotransmitter in the brain) to constrict blood vessels, which may inhibit the pain. Yet while triptans are effective for many migraine sufferers, side effects include nausea, dizziness, dry mouth, and tingling of the skin.

But we've turned a corner. "In the past decade, migraine medicine has grown exponentially," says Nauman Tariq, MD, assistant professor of neurology and director of the Headache Center at Johns Hopkins School of Medicine. "Since 2010, the FDA has approved eight new drugs, compared with only two in the previous decade."

There are two main types of migraine treatments, often used in tandem: preventive and acute (also called rescue or abortive, because it's meant to relieve a migraine headache within two hours). The latest on both:

Preventive meds
A new class of drugs that target a protein called calcitonin gene-related peptide (CGRP) has been life-altering for migraine patients. CGRP lives inside your nerves; when migraine strikes, it gets released and propagates pain, explains David Dodick, MD. New drugs like Emgality, Aimovig, and Ajovy block CGRP receptors to stop a migraine before it starts. These three drugs (plus a fourth that's due this year) are self-injected once a month, and they don't cause some of the worst side effects of standard migraine treatments, such as cognitive dysfunction and fatigue.

Acute meds
The FDA recently approved three new rescue drugs: Ubrelvy (ubrogepant), an oral tablet that blocks the CGRP receptor; Reyvow (lasmiditan), which also can be taken orally and targets a different receptor (serotonin 5-HT1F); and Nurtec (rimegepant), a dissolving oral tablet. Results have been promising: "In roughly 4,000 patients, a higher dose relieved pain within two hours for nearly 40 percent," Tariq says. "We haven't had many options for rescue medicines, so this is exciting."

PERENNIAL PAINS

Other types of headaches may occur at any time in a woman's life.

TENSION HEADACHES

What: You've likely had at least one of these; it feels like pressure or tightness in the head or neck and may last from 30 minutes to a week. More than 70 percent of people experience tension headaches less than 15 times a month, and they affect three women for every two men.
Why: Triggers may include stress, bad posture, muscle tension, and a hectic day.
Try: Managing stress and getting enough rest may help stave off tension headaches. One study showed that inadequate sleep and an inability to let go of daily stress are both risk factors.

SINUS HEADACHES

What: These headaches involve pressure or pain in the sinus area (around the eyes, cheeks, and forehead).
Why: They may be caused by a sinus infection (a.k.a. sinusitis), especially when occurring after a viral upper respiratory infection or cold. Symptoms include decreased sense of smell, pain in one cheek or the upper teeth, and thick, discolored mucus. However, when people think they have a sinus headache, it's actually a migraine 90 percent of the time, according to the American Migraine Foundation.
Try: If over-the-counter pain medicines and decongestants don't help, talk to a doctor.

CLUSTER HEADACHES

What: This relatively rare disorder is characterized by intense headaches on one side of the head (usually behind the eye) and may also include a red or teary eye, a runny or stuffy nose, and a flushed or pale face. Unlike migraineurs, who generally prefer to weather an attack by lying down and staying still, people experiencing cluster headaches may pace or sit and rock back and forth. Cluster headaches usually occur in cycles of up to eight per day—you may get them for a couple of weeks or months at a time, followed by a period (at least a month and up to several years) of no attacks. They're typically reported by men (the male to female ratio is 7–1), but the proportion of women experiencing them increases with age, explains Merle Diamond, MD.
Why: Cluster headaches seem to happen when the trigeminal nerve (the one responsible for sensation in the face) is activated, which is why they lead to eye pain and tearing, says Diamond. Triggers can include seasonal weather changes, alcohol, and nicotine.
Try: Talk to a neurologist ASAP about treatment options. A daily preventive medication such as verapamil can prevent attacks by inhibiting blood vessel dilation in the brain; acute treatments include inhaling pure oxygen through a mask, which can provide relief within 15 minutes, and taking an injectable form of sumatriptan.

OCULAR MIGRAINE

What: A bizarre and rare problem, this includes the loss of sight in one eye or visual disturbances, such as flashing lights or blankness, that occur before a migraine—or even in the absence of any pain at all.
Why: "People who get these may also, but not always, experience other types of migraines," says Diamond. "The vision loss usually lasts only for about an hour or two, but it can be very scary."
Try: Stay calm, and if possible, lie down while you wait for your vision to return. To avoid future attacks, talk to a specialist about preventive therapies, which may include calcium channel blockers (like verapamil) and antiepileptic medications.