Migraine and HRT

Key points

- Perimenopausal migraine is often driven by fluctuating hormones rather than low estrogen.
- Hormone cycle control can potentially treat migraine, menstrual problems and other perimenopausal symptoms together.
- For women with migraine without aura, continuous combined hormonal contraception can be considered. Natural estrogen pills containing estradiol or estetrol are preferred to ethinylestradiol-containing pills.
- Combined hormonal contraception is contraindicated in migraine with aura; progestogen-only approaches can be considered instead.
- HRT and hormonal contraception are different and not interchangeable. The best hormonal approach may change from perimenopause to post menopause.
- After menopause, if HRT is needed, transdermal estrogen with continuous progestogen when required is generally preferred for women with migraine.

How do I know if I am in perimenopause?

Perimenopause is the transition from when periods start to become irregular (typically mid- 40s) until 12 months after the final menstrual period. It is characterised by symptoms associated with fluctuating estrogen levels, menstrual cycle issues, headaches and increased migraine.

How do I know if I have migraine?

Migraine is common, affecting over 40% of women at some point in their lives. However, many women do not realise that their frequent headaches are migraine. If you have recurring headaches, ID Migraine® is a simple tool that can help determine if they are migraine attacks.

ID Migraine®

Answer YES or NO to the following questions:

1. In the last 3 months, have your headaches limited your activities for at least one day?
2. Do you feel nauseated or sick to your stomach when you have a headache?
3. Does light bother you significantly more when you have a headache?

A score of 2 or 3 YES answers suggests that the headaches are migraine.

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Around 70-80% of migraine attacks are migraine without aura, around 20-30% are migraine with aura. Aura starts before the headache and usually affects vision, causing bright shimmering lines or zig-zags, or a patch of blurred or missing vision. Less often it causes a pins-and-needles feeling in one arm or unclear speech. Aura symptoms develop over 20-30 minutes before the headache starts and then disappear completely. In about 1% of cases, aura happens without a headache.

What is likely to happen to migraine during the perimenopause?

Migraine often worsens in the years before menopause, with attacks happening more often and lasting longer. Many women notice that the attacks are more likely to start a few days before or during their periods. These perimenstrual migraine attacks are typically migraine without aura. They often last longer, are more severe and are less responsive to treatment compared to attacks at other times of the cycle. Periods can become erratic and more frequent which also means more migraine.

Following menopause, migraine without aura becomes less of a problem, particularly in women who have noticed a strong link between migraine and hormonal triggers. It is not an immediate improvement as it takes a while after your last period for the hormones to settle. In contrast, migraine with aura is less likely to improve post menopause.

Why does migraine get worse during the perimenopause?

The main reason is the fluctuation of estrogen. This also causes migraine to worsen at puberty, as it takes a few years for the hormones to reach the settled pattern of the menstrual cycle.

From late teens to mid-30s, most women have a regular pattern of menstrual cycle hormones. For some women, the natural drop in estrogen that occurs around menstruation and during the pill-free week of combined oral contraception can trigger migraine. Others find that heavy, painful periods are linked to migraine.

From early 40s, the menstrual cycle can become more erratic, with more variable estrogen levels. Periods can be more troublesome, with more pain and heavier bleeding. All these factors can make migraine more likely. As periods become less frequent, so the hormonal trigger for migraine lessens, which is why many women find migraine improves after the menopause.

Can HRT help perimenopausal migraine?

HRT is very effective at controlling flushes and sweats post menopause but if started too early in the perimenopause, when estrogen levels can fluctuate widely, the addition of HRT can worsen migraine. In contrast, hormone cycle control is an effective treatment option.

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What is hormone cycle control?

The aim of hormone cycle control is to manage perimenopausal migraine by suppressing ovarian activity and creating a more stable hormonal environment (i.e. levelling out your hormones across the cycle). This differs from conventional HRT which adds estrogen to hormones already produced by the ovaries. In early perimenopause, when natural estrogen may already be high and erratic, adding estrogen can increase hormonal instability.

Hormonal contraception is an effective means of hormone cycle control. It can be considered even when contraception is not needed as it can help with other issues that occur during perimenopause:

- hormonal or menstrual migraine
- hot flushes and other perimenopausal symptoms
- heavy, painful or troublesome periods
- premenstrual symptoms
- contraception, if required

But can I take hormonal contraception if I have migraine?

Healthy non-smoking women with migraine without aura can use combined hormonal contraception until age 50. Using it continuously, without the hormone-free interval, helps keep ovarian suppression and prevents an estrogen drop that can trigger migraines. If bleeding becomes an issue, a flexible extended regimen with a short break of up to four days can be used. You can speak to your prescriber to understand more about this.

Traditional combined contraceptive pills contain the synthetic estrogen ethinylestradiol. Newer pills contain natural estrogens such as estradiol (which is the same type produced by the ovaries) and estetrol (another natural estrogen). During perimenopause, pills with estradiol or estetrol are preferred over those with ethinylestradiol because they have a lower risk of blood clots.

However, combined hormonal contraception is not recommended for women with migraine with aura, including those with natural estrogens. Although these newer pills have a good safety profile, there isn't enough evidence to change current guidelines. Hormone cycle control (levelling out of your hormones) can be achieved with an ovulation-suppressing progestogen-only method like drospirenone. If estrogen is needed for menopausal symptoms, continuous transdermal estrogen can be added if medically appropriate.

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What about the hormonal intrauterine device (LNG-IUD)?

A hormonal coil (such as a 52 mg levonorgestrel intrauterine device) can help with heavy menstrual bleeding. However, it mainly works in the womb and does not always suppress ovarian activity. Natural estrogen fluctuations may continue, so while it may improve bleeding is less likely to help estrogen-withdrawal migraine.

Should I have a hysterectomy?

It seems logical to think that removing the ovaries might stop the hormone trigger for migraine. However, the natural menstrual cycle is complex and controlled by the hypothalamus, a brain organ that regulates estrogen and progesterone production by the ovaries. The hypothalamus also plays a role in generating migraine attacks.

Studies show that hysterectomy, with or without removal of the ovaries, can worsen migraine. Removing the womb and ovaries disrupts the hormone cycle, causing brain hormones to initially go into 'overdrive' as they are not prepared for an early menopause. This can initially result in worsening migraine, although this usually settles over the subsequent couple of years.

For women with migraine needing surgery for other gynaecological conditions, this effect can be mitigated with estrogen replacement, particularly if the ovaries have been removed.

Where does HRT fit during perimenopause?

HRT can effectively treat menopause symptoms, but it is not the same as controlling the hormone cycle. If migraine worsens alongside menstrual and perimenopausal symptoms, an important question to discuss with your healthcare professional is:

"Would controlling my hormonal cycle and stabilising hormone levels be more appropriate for me than conventional HRT at this stage?"

My periods stopped four years ago, why do I still get migraine?

Even though your periods have stopped, it can take a few years for the hormone fluctuations to completely settle. This means that you can have hormonal migraine for several years after your last period. Usually this lasts no more than seven years, but some women still get hot flushes and migraine ten or more years after menopause.

Once hormonal triggers settle, non-hormonal triggers remain and may even increase after menopause. Chronic medical conditions, while not directly causing migraine, can make attacks more likely to occur by lowering the migraine threshold. Maintaining good migraine 'habits' – regular meals, regular exercise, a good sleep routine, balancing triggers and looking after your general health – is as important after the menopause as before.

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Where does HRT fit after menopause?

Migraine generally improves after natural menopause as ovarian activity declines, although this is not the case for everyone. Studies show that women using HRT after menopause are more likely to have migraine compared to those who do not use HRT. However, if HRT is needed to manage menopause symptoms, the aim for women with migraine is to maintain steady hormone levels. Hence women with migraine who need HRT should use transdermal estrogen (patch, gel or spray) as this provides more stable hormone levels than tablets. The lowest dose of estrogen needed to control menopausal symptoms is recommended.

Unless a woman has had a hysterectomy, she will also need progestogen to protect the womb lining from thickening in response to estrogen – this could otherwise lead to unwanted changes in the cells. Micronised progesterone may be better for migraine over synthetic progestogens, such as medroxyprogesterone acetate or norethisterone. Micronised progesterone, when taken by tablet, boosts the brain chemical GABA which is thought to be involved in migraine. However, research to confirm this potential benefit is lacking. There is no research on the effects of testosterone gel on migraine.

I have migraine aura. Can I take HRT?

Yes. Unlike combined oral contraception which is not recommended for women with migraine aura, HRT uses natural estrogen similar to that produced by your body during your menstrual cycle. Therefore women with aura can use any form of HRT. However, aura may worsen or occur for the first time after starting HRT, especially with oral estrogen compared to transdermal estrogen. So if you have aura it is advisable to start with transdermal estrogen at the lowest effective dose to control flushes and sweats. This is because transdermal estrogen generally provides more stable hormone levels than oral estrogen. However, if whilst on HRT, you experience a worsening of aura or a new onset, you should seek advice from your HRT prescriber.

What about vaginal estrogen?

Vaginal estrogen helps control vaginal and urinary symptoms related to menopause, regardless of HRT use. Symptoms include vaginal dryness, pain, urinary urgency and recurrent infections. Vaginal estrogen might temporarily increase migraine during the first couple of weeks but this usually settles. There is no evidence that long-term use of vaginal estrogen triggers migraine.

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What non-hormonal ways are there to help migraine?

Hormonal management is just one part of migraine care. Regular meals, good sleep, physical activity and stress management can help. Migraine attacks should also be treated with effective symptom medication and preventive treatment considered if attacks are frequent or poorly controlled. Non-hormonal options for prevention of both migraine and hot flushes include escitalopram and venlafaxine. These drugs act on the chemical messenger serotonin which is implicated in both conditions. Keeping a headache and menstrual diary can help identify hormonal patterns and assess treatment effects.

Summary

Migraine during perimenopause is often caused by hormonal fluctuations rather than low estrogen levels. HRT and hormone cycle control have distinct purposes and should not be used interchangeably. The most appropriate hormonal strategy may differ from perimenopause to post menopause.

Author: Professor Anne MacGregor in collaboration with the medical advisory council of the British Menopause Society.

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This Women's Health Concern fact sheet provides information and guidance, to be used in consultation with your own healthcare professional. It will be updated when guidance changes and/or new data becomes available.

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