

Understanding Menstrual Migraine:

The Experiences, Barriers, and Unmet Needs of U.S. Women

Findings from the National Women's Migraine Survey



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Executive Summary

Menstrual migraine is not a side effect of having a period. It is a clinically recognized, mechanistically distinct subtype of migraine that affects approximately 50% of women with migraine across the United States,^{1,10} producing attacks that are, on average, more severe, more resistant to treatment, and more disabling than migraine at other times of the month.

New data from the National Women's Migraine Survey — a 2026 survey of 225 U.S. women, all confirmed to experience migraine attacks linked to their menstrual cycle — paints a clear picture of a condition that is largely undermanaged, under-diagnosed, and poorly treated despite being highly predictable.

24%

of respondents have a proactive management plan for attacks linked to their menstrual cycle

Even though 96% of respondents say they can predict attacks related to their menstrual cycle, only just 1 in 4 women have a proactive management plan. 7 in 10 women have not discussed short-term prevention with a healthcare provider (HCP). More than a third have never received a prescribed treatment for their period-related attacks.

36%

of respondents have not received a prescribed treatment or period-related attacks

This is the predictability paradox at the center of this report: women know their attacks are coming, but most do not have the clinical support or the information or an effective treatment to act on that knowledge.

The menstrual migraine burden is real and recurring. 6 in 10 women lose three or more days to migraine every menstrual cycle — equivalent to more than 36 days per year, for what may be decades. 7 out of 10 miss work or school. 8 in 10 experience anxiety or dread about upcoming periods which may further compound the severity of the menstrual migraine attacks.

71%

of respondents miss work or school due to menstrual migraine attacks

This white paper brings together findings from the National Women's Migraine Survey, clinical insights from Migraine World Summit experts, and published research to document the state of menstrual migraine care in the United States. Its purpose is to name the gaps clearly, illuminate what is possible, and support women in advocating for care that reflects the reality of their condition.

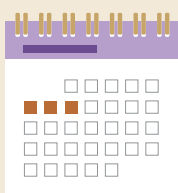
Menstrual Migraine: The Hidden Burden and Missed Care Opportunity

THE PREDICTABILITY PARADOX

Women can see attacks coming. Most don't have a plan to meet them



THE BURDEN



6 in 10 women lose three or more days every cycle

36+ days a year

Days affected by menstrual migraine Other days

7 in 10 respondents miss work or school due to menstrual migraine attacks



THE DIAGNOSIS

76%

lack a menstrual migraine diagnosis despite all respondents experiencing cycle-linked attacks

3 in 4

women whose migraine is clearly tied to their cycle don't have the diagnosis that could unlock cycle-specific care



8 of 10

say migraine attacks around their menstrual period are typically more severe than at other times of the month

“

NSAIDs for 25% of our lives is not reasonable. We need actual treatment options.

— SURVEY RESPONDENT, AGE 39, EXPERIENCING MENSTRUAL MIGRAINE SINCE AGE 11 —

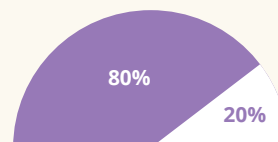
TREATMENT GAP

70%



have not discussed short-term prevention with a provider

ANTICIPATORY BURDEN



80%

feel anxiety or dread about upcoming periods

EFFECTIVENESS CONTRAST

Acute migraine prescription 82% vs general pain prescriptive 42% — nearly 2× effective

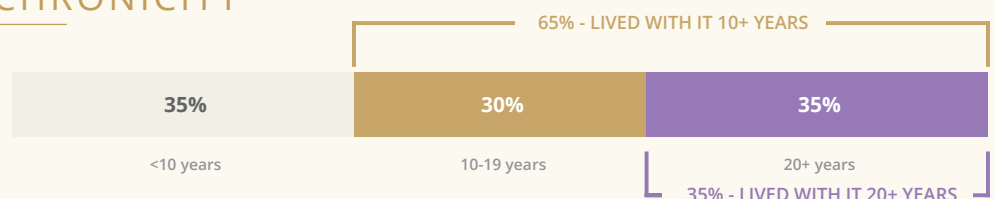
OTC pain medication

Prescription acute migraine medication

42%
82%

70% told their symptoms are "normal" or "just hormonal."

CHRONICITY



Methodology and Survey Subjects

Study design

The National Women's Migraine Survey is a cross-sectional study led by the Migraine World Summit and World Health Education Foundation, combining quantitative self-reported data with qualitative open-ended responses. This design was chosen to capture both the measurable dimensions of menstrual migraine experience (diagnosis rates, treatment usage, attack frequency and severity, and daily impact) and the personal, narrative dimensions that structured data alone cannot convey.

The study was conducted in February 2026 as part of a broader women's migraine health initiative supported by funding from Pfizer Medical Affairs. Pfizer had no role in managing the survey and did not have access to individual responses. All responses were confidential and reported in aggregate only. The study was conducted in accordance with best practice research and ethical standards for observational, non-interventional research. No formal institutional review board (IRB) process was required.

Participants and eligibility

A total of 225 U.S. women completed the survey in full. To be eligible, respondents were required to meet four criteria: be a U.S. resident, be between the ages of 18 and 50, currently menstruate at least six times per year, and experience headaches that occur between two days before and three days after the start of their menstrual period.

The menstruation frequency threshold was set deliberately, as the clinical definition of menstrual migraine is tied to the timing of active menstrual bleeding and the assessment of current cycle-based patterns. Recruitment was conducted through the Migraine World Summit subscriber and community network, an engaged patient and health information-seeking audience drawn from the U.S. migraine community.

The majority of respondents (94%) were aged 30 to 50, reflecting the peak burden years for menstrual migraine. A total of 162 respondents provided open-ended qualitative responses, which are used throughout this report to substantiate and contextualize the quantitative findings.

Quality appraisal: MMAT criteria

MMAT alignment. The Menstrual Migraine Assessment Tool (MMAT) is a simple, three-question screening tool developed to identify menstrual migraine (MM) in clinical settings. It assesses the timing of headaches relative to menstruation, pain severity, and light sensitivity (photophobia) to distinguish true menstrually related headaches. Of the three screening questions, respondents in this study qualified if they answered "yes" to the timing question: "Do you have headaches that are related to your period (i.e., occur between 2 days before the onset of your period, until the third day of your period) most months?" Data for the remaining two questions were collected (pain severity and light sensitivity) but not used as qualification criteria.⁶

Research questions. The survey was designed around clearly defined research questions focused on five domains: diagnosis status and barriers, treatment usage and effectiveness, attack predictability and preparedness, hormonal transitions across the lifespan, and daily functioning and quality of life.

Sampling strategy. Recruitment through the Migraine World Summit network is relevant to the research questions: the audience is drawn from an engaged, health-informed migraine community, increasing the likelihood that respondents have genuine clinical experience with the condition under study. Specifically, the requirement to be currently menstruating at least six times per year was included to ensure respondents had regular cycles that allow reliable assessment of cycle-

linked migraine patterns. This approach is aligned with ICHD-3 definitions, which relate menstrual migraine to the timing of menstrual bleeding.¹¹ Including women who do not currently menstruate would introduce retrospective recall and a different hormonal framework, reducing comparability with established clinical definitions.

Qualitative component. An open-ended question was included in the survey to allow respondents to describe their experiences in their own words. A total of 162 respondents provided open-ended responses to the following question: What is the one thing you wish healthcare providers better understood about diagnosing or treating migraine related to menstruation? Responses were reviewed for recurring themes and are used throughout this report to contextualize and extend the quantitative findings. The qualitative data are presented as complementary evidence rather than as a standalone thematic analysis.

Limitations

The sample is not a nationally representative probability sample, and findings should be interpreted as indicative of the experiences of this population rather than as precise population-level estimates. The demographic concentration (94% aged 30–50, U.S. only) reflects

the intended target population, though it limits the generalizability of findings to younger women, to those menstruating less than six times per year, and those outside the United States.

Non-probability sampling via an opt-in patient community means that sample characteristics reflect those of the community and do not extend to the full spectrum of women with hormonal migraine. Recruitment through an engaged migraine audience may over-represent women who are actively seeking information about their condition and under-represent those with lower health literacy or access to specialized care.

Non-response bias cannot be formally quantified without data on those who did not complete the survey. The eligibility requirement to currently menstruate at least six times per year means the sample formally excludes women with highly irregular cycles, those using certain hormonal contraceptives that suppress menstruation, those in perimenopause with infrequent cycles, and post-menopausal women. The sample is also geographically limited to the United States. These limitations are acknowledged in the context of a study that offers a substantive evidence base for understanding the lived experience, care gaps, and unmet needs of this population.

SECTION 1:

What Is Menstrual Migraine?

Migraine is a neurological disease affecting more than one billion people worldwide. It is three to four times more common in women than in men, a disparity rooted, in significant part, in the influence of female sex hormones on the nervous system.¹² Among women of reproductive age (15–49), migraine is the leading cause of disability worldwide.¹⁵

A substantial proportion of women who experience migraine find that attacks are connected to the menstrual cycle. Menstrual migraine refers to migraine attacks that are linked to the timing of menstruation, including both pure menstrual migraine and menstrually related migraine. There are two formally recognized subtypes.¹¹

PURE MENSTRUAL MIGRAINE:

Attacks occur exclusively in the perimenstrual window, from two days before the onset of bleeding to three days after (days -2 to +3), and at no other time of the month.

MENSTRUALLY-RELATED MIGRAINE:

Attacks occur perimenstrually but also at other points in the cycle. Most women with hormonal migraine fall into this category.

Perimenstrual refers to the days around menstruation, from two days before bleeding starts to three days after (days -2 to +3).



The biological mechanism



Dr. Christine Lay,
Professor of Neurology at the
University of Toronto

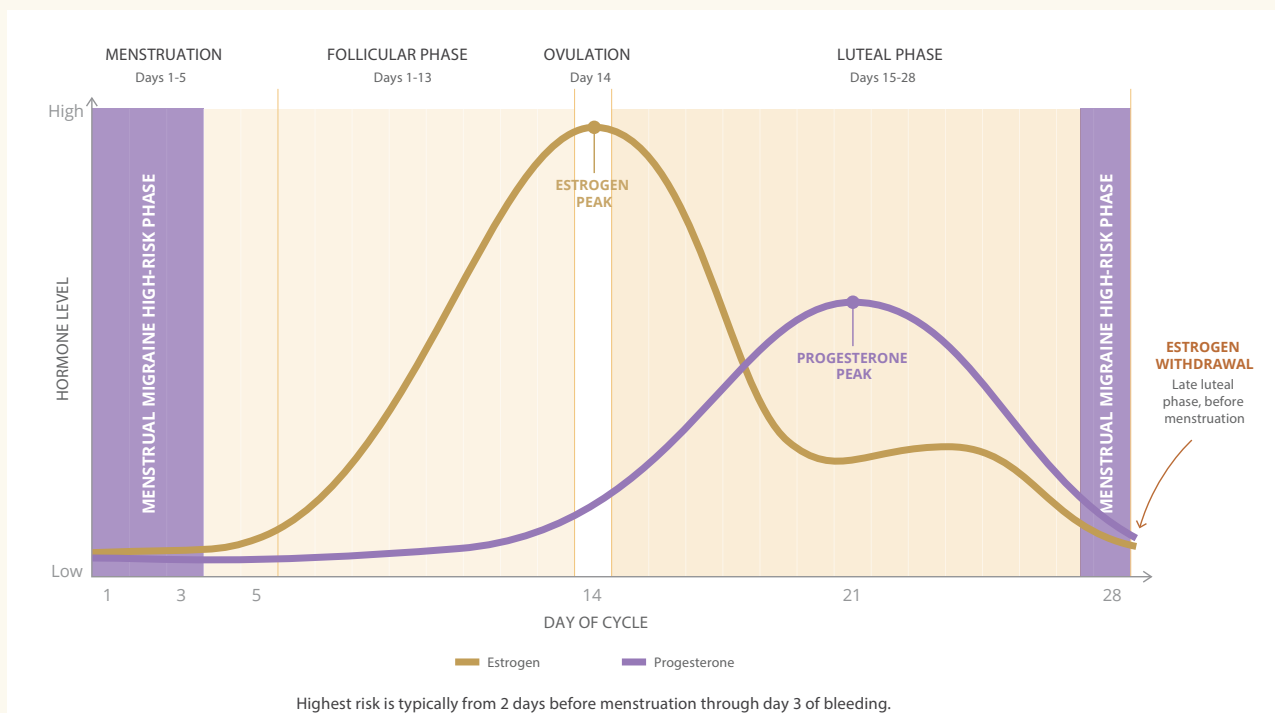
In the days leading up to menstruation, called the luteal phase, estrogen and progesterone levels fall. In women with migraine, this hormonal shift appears to occur more abruptly. Dr. Christine Lay, Professor of Neurology at the University of Toronto, has described this directly: “The drop in estrogen right before the beginning of a menstrual cycle is much more rapid in a woman who has migraine than in a woman who does not have migraine.”

This accelerated estrogen withdrawal is believed to increase susceptibility to the neurological cascade that produces a migraine attack. The interaction between estrogen and CGRP may further increase this risk. When estrogen levels are high and stable, they appear to suppress calcitonin gene-related peptide (CGRP), a key molecule involved in migraine pain signalling. When estrogen declines, CGRP signalling increases, and migraine risk rises correspondingly.¹

Estrogen withdrawal may also increase susceptibility to prostaglandins, inflammatory compounds released during menstruation that can promote neuroinflammation via CGRP release, providing an additional pathway that may increase migraine risk in some women.¹

Estrogen and progesterone levels during the menstrual cycle

Why late-cycle estrogen withdrawal matters for migraine



Curves represent typical relative hormone levels across an idealized 28-day cycle.

What makes menstrual migraine more severe

Menstrual migraine attacks are not just typical migraine attacks occurring around menstruation. They tend to be longer in duration, more resistant to treatment, and more severe.¹ Research suggests that the low-estrogen environment around menstruation may reduce the effectiveness of triptans — the most widely used acute migraine treatments — possibly because estrogen and serotonin systems are interlinked, and triptans act on the serotonin pathway.¹³ The same medication that controls an attack at other times in the cycle may be less effective during the perimenstrual period.

MORE SEVERE

81%

say migraine attacks around their menstrual period are typically more severe than at other times of the month

HARDER TO TREAT

69%

say migraine attacks around their period are harder to treat than attacks that occur at other times of the month

These collective findings confirm a clear clinical picture. Since menstrual migraine is mechanistically distinct, it warrants its own recognition, its own treatment strategy, and its own diagnosis. Treating it as undifferentiated migraine has the potential to leave a substantial proportion of women without the targeted support they need.

“I know my body and when I am experiencing migraine. How debilitating it is to know that you will have a migraine that will disrupt your life every month.”

SURVEY RESPONDENT

SECTION 2:

How Women Experience It

Menstrual migraine is not only defined by when it occurs, but by how it is experienced. This section examines the real-world impact of the condition, using survey data to reveal a consistent pattern: attacks are predictable, yet most women remain underprepared and under-supported.

Predictable but not prepared



Dr. Susan Hutchinson
UCNS-certified headache
specialist and founder of
Orange County Migraine
& Headache Center

Perhaps the most striking finding in the survey is the gap between prediction and preparedness. An extraordinary 96% of respondents describe their menstrual migraine attacks as very or somewhat predictable. For a recurring condition, that degree of forewarning should, in principle, be an asset. As Dr. Susan Hutchinson, a UCNS-certified headache

specialist and founder of Orange County Migraine & Headache Center, has put it: “the nice thing is it’s predictable, so that can help lend to treatment because we can target treatment just around that vulnerable time of the month.”¹⁷

Yet just 24% of women surveyed have a proactive management plan in place. More than half (52%) manage reactively — waiting for the attack to arrive before taking any action. 7 in 10 (70%) are not using short-term prevention strategies, despite these approaches being clinically established specifically for women with predictable menstrual attacks.¹⁴

THE PREDICTABILITY PARADOX

96%

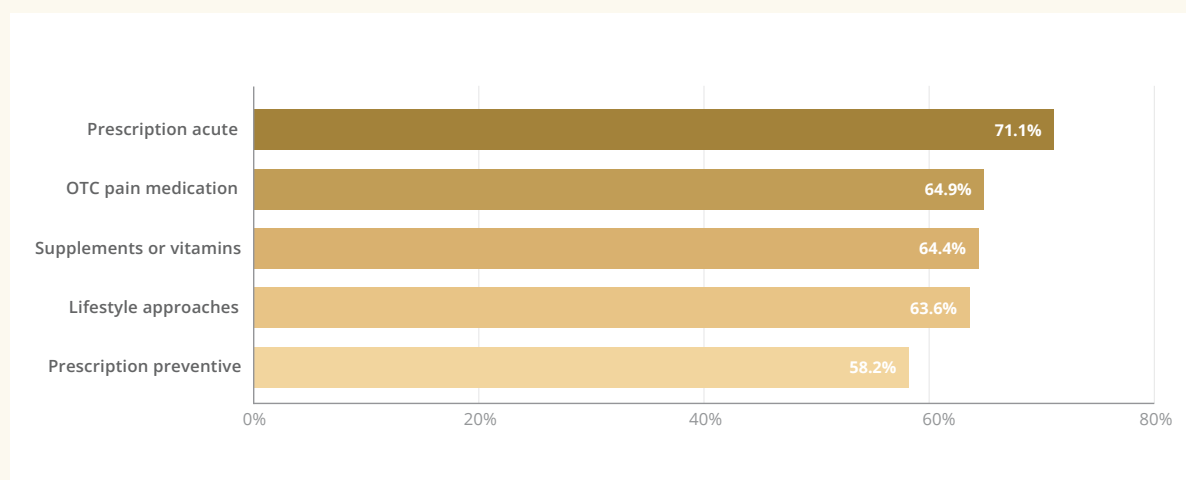
of women can predict their attacks.

Just 24% have a proactive plan. The forewarning exists. The clinical tools exist. The connection between the two is, for most women, absent.

Source: National Women's Migraine Survey, 2026

Current approaches used to manage menstrual migraine attacks

% of women currently using each approach (multi-select, n=160)

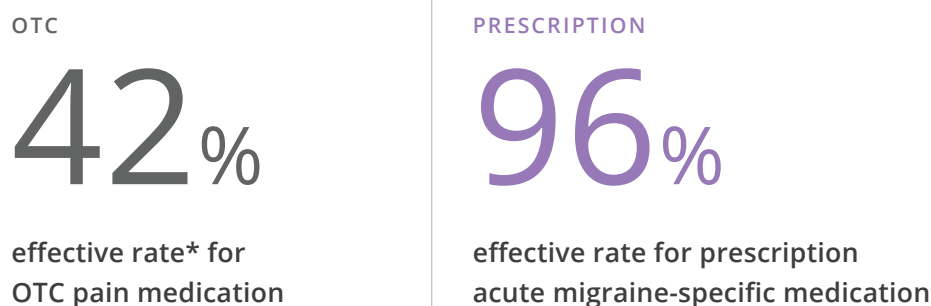


Source: National Women's Migraine Survey, 2026.

Severity and treatability

The survey confirms what clinicians have long observed: menstrual migraine attacks are not the same as attacks at other times of the month.^{1,2,3} 81% of respondents describe attacks as somewhat or much more severe than their non-menstrual migraine attacks. Nearly 7 out of 10 respondents (69%) say attacks around their period are harder to treat.

A COMPARISON OF TREATMENT EFFECTIVENESS TELLS A CONSISTENT STORY



*Effectiveness rate = % of Respondents who rated treatments as "very" or "somewhat effective" to manage attacks around their period.

Prescription acute medications are twice as effective as OTC options for menstrual migraine. However, the effectiveness advantage of prescription acute treatment is not yet translating into prescription-first approaches across the board. With 65% of respondents relying on OTC medication as part of their approach, and OTC effectiveness running at less than half that of prescription alternatives, there is a clear opportunity to shift more women toward the treatments that work best for their specific pattern of attacks.

What women use, what works, what they have stopped

Beyond acute treatment, the survey reveals an opportunity to improve menstrual migraine prevention. 58% of respondents use preventive migraine medication, with 72% finding it effective ("very/somewhat").

Only 18% of respondents use hormonal treatments for their menstrual migraine. Among those who do, 56% rate them as effective, with 24% rating them "very effective." That "very effective" rate sits below prescription acute medication but above prescription preventive treatment, and is noteworthy given how few women are using hormonal approaches at all.

The pattern this creates is worth noting: low uptake alongside meaningful effectiveness among those who use hormonal treatment. This does not point to a clear explanation, and the underlying drivers remain uncertain. It may reflect factors such as access, awareness, clinical decision-making, patient preference, or other influences that are not captured in this dataset.

What is clear is that a gap exists between the number of women using hormonal approaches and the proportion who report benefit from them. Understanding why this gap persists is an important area for further investigation, particularly to determine which women may benefit most and how they can be better supported in accessing appropriate care.

Of the 36% of respondents who have stopped or changed a treatment, the leading reasons were lack of effectiveness (55%), side effects (52%) and concerns about long-term risks (34%). Each reflects a specific, addressable clinical imperative: guidance on what to expect, clear information on when to persist or adapt, and transparent conversations about risk.

Duration and impact on daily life

60% of respondents report being significantly impacted by migraine on three or more days per menstrual cycle. Over a year, this equates to at least 36 days affected.

This aligns with definitions from American College of Obstetricians and Gynecologists (ACOG), which indicate that menstrual cycles typically occur every 21–35 days, resulting in approximately 10–17 cycles per year.¹⁶ This corresponds to an estimated 30–51 days annually with significant impact.

Menstrual migraine is therefore not an occasional event, but a recurring, monthly disruption that accumulates over years and decades.

Two out of three respondents (65%) have lived with menstrual migraine for at least a decade, including 35% who have experienced it for more than 20 years.

“

NSAIDs for 25% of our lives is not reasonable. We need actual treatment options

SURVEY RESPONDENT, AGE 39,
EXPERIENCING MENSTRUAL
MIGRAINE SINCE AGE 11

“

I know my body and when I am experiencing migraine. How debilitating it is to know that you will have a migraine that will disrupt your life every month.”—

— SURVEY RESPONDENT, AGE 34, EXPERIENCING MENSTRUAL MIGRAINE SINCE AGE 21 —

“It wasn’t until this year that my GP suggested that my almost chronic headaches could be hormone related... none of [my neurologists] ever asked or suggested that my migraines were related to my menstrual cycle. I feel that women’s health, on the whole, is mostly ignored or downplayed in healthcare.”

SURVEY RESPONDENT



The Diagnosis Gap

Clinical research suggests that approximately 50% of women with general migraine also experience cycle-linked migraine attacks,¹ and that menstrual migraine affects up to 22% of menstruating women when assessed by a specialist.⁶ The condition has long been recognized as substantially underdiagnosed in primary care.⁶ The data from this survey reflects that pattern directly.

Among the 225 women who all experience cycle-linked migraine attacks in the National Women's Migraine Survey, just 2% have received a formal diagnosis of pure menstrual migraine. 22% have been diagnosed with menstrually-related migraine. The remaining majority carry diagnoses of general migraine (63%), chronic migraine (67%), or migraine with aura (40%) — without the menstrual specification that could open the door to cycle-targeted management.

The diagnostic label, or lack thereof, shapes clinical decisions. Without a menstrual migraine diagnosis, short-term prevention strategies tailored to the perimenstrual window may be less likely to be offered, hormonal approaches less likely to be considered, and cycle-specific planning less likely to happen.

Why the diagnosis is missing

The survey asked respondents why they had not received a specific menstrual migraine diagnosis.

THREE FINDINGS STAND OUT:

- **The most common reason — cited by 30% of respondents — was that they were told their symptoms were “normal” or “just hormonal.”** This normalization reflects a broader cultural pattern: period pain, headaches, and hormonal disruption are widely accepted as inevitable, even by clinicians, meaning the menstrual link often goes uninvestigated despite patients presenting with symptoms.
- **20% of respondents said their provider had never asked about their menstrual cycle in the context of their migraine care.** This represents a missed clinical opportunity that requires nothing more than a short series of questions to address.
- **14% did not recognize the connection between their cycle and their migraine themselves.** This is a knowledge gap that patient education can directly close.

VALIDATED SCREENING TOOLS

A simple, one minute MM screening tool migraine screening tool for use in OB/GYN and primary care settings was published in 2008 and is available for clinical use. Its underuse is itself a gap.

The Menstrual Migraine Assessment Tool (MMAT)

A validated three-question screening tool for menstrual migraine, the MMAT, was published by SJ Tepper and colleagues in 2008 in *Headache: The Journal of Head and Face Pain* for use in OB/GYN and primary care settings. It asks whether a patient experiences period-related headaches, whether those headaches become severe, and whether they cause light sensitivity. A positive screen requires a yes to the first question and at least one of the other two. The tool takes under a minute to administer.

In validation studies, the MMAT demonstrated high sensitivity (0.94), meaning it correctly identifies the vast majority of women (94 out of 100) who have menstrual migraine.



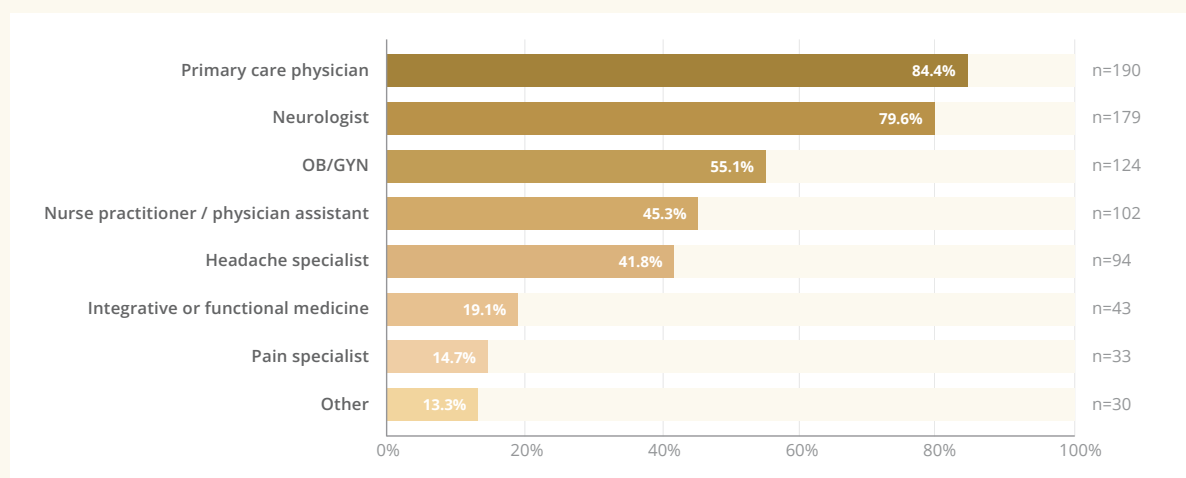
Dr. Stewart J. Tepper,
Professor of Neurology at the
Geisel School of Medicine at
Dartmouth

“Menstrual migraine should not be left to chance recognition. When attacks reliably occur around menstruation, clinicians have a clear opportunity to ask the right questions, accurately diagnose the condition specifically, and connect women to a more targeted treatment strategy. Simple screening tools can make that possible in routine care.”

In the OB/GYN validation study, 22% of routine patients screened positive for some form of menstrual migraine. The tool has been available for clinical use for nearly two decades yet it has not been incorporated into American College of Obstetricians and Gynecologists clinical practice guidelines or formally endorsed by major headache societies as a standard screening instrument.

Healthcare providers consulted about migraine or headache symptoms

% of respondents who have ever discussed symptoms with each provider (multi-select, n=225)



0% reported never having discussed migraine or headache symptoms with any healthcare provider. Source: National Women's Migraine Survey, 2026.

This survey used an abridged version of the MMAT, with Question 1 serving as the primary eligibility screener. All 225 respondents reported experiencing headache attacks linked to their menstrual cycle. Responses to the remaining MMAT items were collected as survey data: 94% indicated these attacks become severe, and 85% reported light sensitivity. Based on the MMAT criteria, 99% of respondents would screen positive for menstrual migraine.

Where women seek care

The survey asked respondents which providers they had discussed migraine or headache symptoms with — not specifically menstrual migraine. On that basis: 84% had spoken with a primary care physician; 79.6% with a neurologist; 55% with an OB/GYN; and 42% with a headache specialist.

These figures tell us where this health-engaged population of women are raising migraine as a concern. They do not tell us where it is being managed, nor whether the hormonal dimension is being explored. That distinction matters.



Dr. Jessica Ailani
MD, Director of MedStar
Georgetown Headache Center

The training gap is a key part of the explanation. As Jessica Ailani, MD, Director of the MedStar Georgetown Headache Center, has observed, the hormone-migraine connection is not well covered in medical education: “There aren’t many lectures on hormone cycles and migraine. Unless headache specialists have a mentor focused on this, or see in practice how

common it is, many don’t fully understand the close connection between hormone changes and migraine.”⁸ If that gap exists even within headache specialties, it is likely far more pronounced across the primary care and OB/GYN settings where most women in this survey first raised the issue. What drives better identification and management is migraine and hormonal expertise, not the clinical setting itself. That expertise is not consistently present across the providers women most commonly see.

It is notable, then, that 82% of respondents say they have addressed menstrual migraine symptoms specifically with a healthcare provider. Yet the formal diagnosis rates tell a different story: those conversations are happening, but it is not consistently translating into a formal diagnosis or cycle-targeted management.

“

It wasn’t until this year that my GP (female) suggested that my almost chronic headaches could be hormone related, which made me reconsider my whole past experiences with Neurologists (all male), none of which ever asked or suggested that my migraines were related to my menstrual cycle. I feel that women’s health, on the whole, is mostly ignored or downplayed in healthcare.—

— SURVEY RESPONDENT, AGE 35,
EXPERIENCING MENSTRUAL MIGRAINE SINCE AGE 29 —

The cost of going unnamed

A diagnosis is not just a label. For women with menstrual migraine, it is the gateway to short-term prevention, to hormonal management discussions, to cycle-specific planning, and to being understood by providers across multiple specialties. The absence of a diagnosis leaves women managing a recognized condition without its name, and without the management strategies that follow from it.

The open-ended responses in the survey return repeatedly to the same request: *be asked, be listened to, be taken seriously*. “Screen for this more thoroughly earlier on,” wrote one respondent. Another respondent expressed a simple wish: that this “would be a conversation that more healthcare providers would bring up for people who menstruate as part of a care plan.”

The diagnosis gap can be reversed. A trained eye, a few key questions, and a willingness to name what women experience would go a long way towards addressing the unmet needs among women living with menstrual migraine.

80% of respondents
felt **anxiety** or
dread about
upcoming periods at
least sometimes.

Source: National Women's Migraine Survey, 2026 (n=225)



SECTION 4:

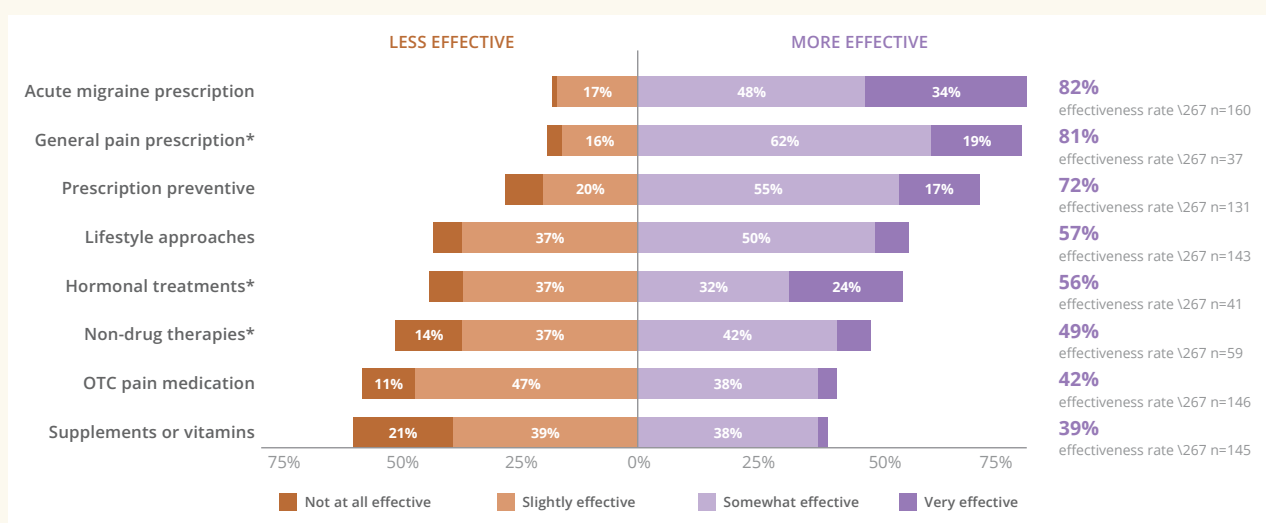
The Treatment Gap

Effective treatment options for menstrual migraine exist. The challenge is not a lack of clinical tools but a gap in how consistently those tools reach women, and in the guidance provided to use them well.

Acute treatment: the case for prescription over OTC

How effective is each approach in managing menstrual migraine attacks?

Distribution of effectiveness ratings, sorted by % rated effective ("somewhat" or "very")



Effectiveness rate = % rating "very" or "somewhat" effective. *Smaller sample size (n<60) - interpret with caution. Source: National Women's Migraine Survey, 2026.

Prescription acute migraine-specific medication is the most-used treatment among respondents, with 71% reporting current use. Over-the-counter pain medication (65%), supplements or vitamins (64%), and lifestyle approaches (64%) are used at statistically similar rates. Prescription migraine preventive medication is used by 58% of respondents, statistically lower than prescription acute use.



Dr. Jelena Pavlović,
Associate Professor of Neurology
at the Albert Einstein College of
Medicine

The effectiveness picture is not equal across these approaches. **OTC pain medication is among the least effective options, with just 42% of users rating it as somewhat or very effective for period-related attacks.** Prescription acute medications, including triptans and newer CGRP-targeted agents, show substantially better outcomes, with 83% of users rating them effective.

However, this relative advantage does not mean these treatments perform optimally in all contexts. Menstrual migraine is often more difficult to treat than attacks at other points in the cycle. In the perimenstrual window, falling estrogen levels may reduce serotonin availability, which can blunt triptan response. As Dr. Jelena Pavlović, Associate Professor of Neurology at the Albert Einstein College of Medicine has noted: "menstrually related attacks are the most burdensome — associated with most symptoms of migraine, most refractory to treatment, lasting the longest."²

This does not diminish the case for prescription treatment, but it does reinforce why treatment selection and timing within the perimenstrual window matter, and why some women may need a different triptan, a higher dose, or a combination approach for their menstrual attacks specifically.

Short-term prevention: the most underused clinical strategy

For women with predictable menstrual migraine, which describes 96% of survey respondents, short-term prevention represents one of the most underused approaches available.

Short-term prevention involves taking a short course of medication in the days leading up to and during the expected attack window. Longer-acting triptans such as frovatriptan, taken twice daily for five days around the anticipated perimenstrual window, have established evidence for reducing the frequency and severity of menstrual attacks. NSAID-based protocols and magnesium supplementation are also used in this context.^{2,3}

SHORT-TERM PREVENTION: WHAT IT IS

A short course of medication taken in the days before an expected menstrual migraine attack, using the predictability of the cycle to prevent the attack before it starts. Requires a regular-enough cycle to time correctly, and clinical guidance to initiate.

Short-term prevention works precisely because menstrual migraine is predictable. Yet just 26% of respondents have discussed short-term prevention with their healthcare provider. The broader management picture reinforces why this matters: 52% of respondents describe their overall approach as reactive (treating attacks only after they start), while just 24% plan proactively. A further 23% say their approach varies depending on the cycle. Short-term prevention is the clinical tool that converts predictability into a proactive strategy — yet the majority of women who could benefit from it are not using it.

Barriers include irregular cycles that complicate timing, a lack of clinical guidance on how to initiate the approach, and — in many cases — simply not knowing the option exists.^{2,3}

Hormonal approaches: undertapped and underexplained

Only 18% of respondents use hormonal treatments for their menstrual migraine, yet 56% of those who do report them as somewhat or very effective. While this overall effectiveness is moderate compared to other prescription options, a notable proportion of users report strong benefit, with nearly one in four describing these treatments as very effective.

This pattern suggests that hormonal approaches may play an important role for a subset of women, rather than representing a broadly applicable solution. Their lower uptake could reflect a combination of clinical considerations, including contraindications, life stage factors, and prescribing complexity, as well as the smaller number of respondents using these treatments in this dataset.

Hormonal strategies for menstrual migraine typically work by stabilizing the estrogen drop associated with perimenstrual attacks. Options vary by life stage and individual clinical profile. For women without migraine with aura, certain combined hormonal contraceptives used without a hormone-free interval can help prevent estrogen withdrawal. Estrogen supplementation during the perimenstrual window is another established approach.¹

For women with migraine with aura, combined hormonal contraception is generally contraindicated due to increased stroke risk — a constraint that multiple survey respondents explicitly raised as a source of frustration and a barrier to treatment. Progesterone-only options and other non-estrogen approaches exist but require clinical guidance that respondents report is frequently absent.

“

I cannot take many types of birth control because I also have migraine with aura. The ones that are available to me have made my migraines worse. Doctors get frustrated with me for this.

—— SURVEY RESPONDENT, AGE 40, EXPERIENCING MENSTRUAL MIGRAINE SINCE AGE 30 ——

Why people stop: the information gap

More than a third of respondents (36%) have stopped or changed a treatment they were prescribed. The leading reasons were lack of effectiveness (55%), side effects (52%), and concerns about long-term risks (34%). These are not reasons rooted in reluctance. They reflect a clinical treatment pattern that is not yet working well enough for a substantial proportion of the women who engage with it.

Treatment for menstrual migraine is not a single answer. It is a spectrum, shaped by cycle regularity, attack frequency and severity, life stage, comorbidities, and individual preference. Women navigating this spectrum benefit from an informed, collaborative clinical relationship. The survey data suggests many are not currently receiving one.

A woman with dark hair tied in a bun is sitting at a wooden desk. She is wearing a dark blue sweatshirt and jeans. Her head is resting on her hand, and she is looking down at a laptop and an open notebook on the desk. A black water bottle is on the desk to the left. In the background, there is a window with blinds and a small plant hanging from the sill. A bed with a pink pillow is visible in the background to the right.

"It is **REAL**. My symptoms were **dismissed for years**. I was told it was 'all in my head' or '**just part of normal periods**.' This caused me to suffer physically and mentally."

SURVEY RESPONDENT

Hormones Across the Lifespan

Menstrual migraine is not a static condition. It evolves, often significantly, across the hormonal transitions of a woman's life. Understanding these transitions is essential both for individual women managing the condition and for providers seeking to anticipate and address it proactively.

The early years: onset and adolescence

For many women, menstrual migraine begins early. 19% of survey respondents trace the onset of their cycle-linked migraine to early adolescence (ages 10 to 14). A further 18% place onset in late adolescence (ages 15 to 19). Combined, more than a third of respondents experienced the beginnings of this condition before reaching adulthood.

Despite this, 32% of respondents could not identify a specific life stage, event, or trigger associated with the onset of menstrual migraine symptoms. This lack of clarity may help explain why period-related migraine is often normalized, particularly among younger women and girls. Without a clear starting point, patterns can go unrecognized, allowing years of unmanaged migraine attacks to accumulate before the condition is identified and understood.

Hormonal contraception as an inflection point

11% of respondents report their menstrual migraine began or worsened after starting or changing a hormonal contraceptive. This is consistent with evidence that hormonal changes associated with contraceptive use can affect migraine susceptibility. **Sudden cessation of hormonal contraception is associated with an increase in attacks that are both severe and long-lasting**, reflecting the broader principle that declining or unstable estrogen increases CGRP signalling and migraine risk.¹

Removing that withdrawal can change the picture. Continuous combined hormonal contraception eliminates the hormone-free interval and may reduce or prevent perimenstrual attacks. However, for women with migraine with aura, combined hormonal contraception carries stroke-risk concerns and is generally contraindicated, limiting this approach.

The contraception-migraine conversation belongs routinely in any clinical discussion about hormonal birth control for women with migraine. The survey findings suggest this connection is not consistently translated into targeted management or informed contraceptive decision-making.

Pregnancy and the postpartum period

For many women, pregnancy brings a reprieve. Stable, elevated estrogen levels during the second and third trimester are associated with a reduction in migraine frequency and severity for a substantial proportion of women.¹ 12% of respondents, however, trace onset or worsening to the postpartum period, when estrogen levels fall rapidly and breastfeeding further suppresses hormonal cycling. Treatment options during pregnancy and breastfeeding are significantly constrained, creating additional complexity in management during this period.

Perimenopause: the highest-risk transition

Perimenopause is widely recognized as a challenging phase for migraine, driven by increased hormonal variability. Among the 8% of survey respondents who trace onset of menstrual migraine symptoms to their 40s, two-thirds (65%) point to perimenopause specifically as the triggering event. This reinforces the broader impact of hormonal transitions across the migraine lifecycle.

HORMONAL TRANSITIONS

65%

Two-thirds point to perimenopause specifically as the triggering event

Source: National Women's Migraine Survey, 2026

As women approach menopause, ovarian function becomes irregular, and estrogen levels begin to fluctuate widely before eventually declining. This hormonal instability, characterized by higher estrogen peaks and more rapid withdrawals than the relatively stable reproductive years, can dramatically worsen menstrual migraine before it eventually resolves for many women. Dr. Christine Lay has noted that changes in migraine patterns can be among the earliest observable signs that perimenopause is beginning, predating hot flashes and other commonly recognized symptoms by months or even years.

For a woman with a long history of menstrual migraine, an unexplained worsening in her late 30s or early 40s may be a perimenopause signal that is currently going unrecognized and unaddressed.⁴

Hormone replacement therapy: timing matters

A common assumption is that HRT will improve migraine for perimenopausal women. The clinical reality is more nuanced. During perimenopause, estrogen levels can fluctuate widely before eventually settling after menopause. Because migraine is often sensitive to hormonal instability, the timing, dose, and formulation of HRT can make a significant difference. For some women, starting HRT during an already unstable hormonal phase may worsen symptoms rather than improve them.⁵

This does not mean HRT should be avoided in all women with migraine. Rather, it reinforces the need for individualized assessment, careful timing, and coordination between clinicians who understand both menopause management and migraine.

KEY MESSAGE

Women with menstrual migraine should be prepared for perimenopause before they reach it — not left to navigate an unexplained worsening after it has already arrived. The transition is anticipated and manageable, but requires advance planning.

After menopause

After natural menopause, when estrogen levels stabilize at a consistently lower level, migraine improves in the majority of women. This pattern is supported by evidence of decreased plasma CGRP postmenopause, which may contribute to reduced migraine prevalence and severity.¹

Outcomes vary by migraine subtype. Women with hormonally-driven migraine without aura are most likely to improve after the final menstrual period, while migraine with aura is less likely to improve and may, in some cases, emerge for the first time postmenopause (MacGregor, MWS 2023). In contrast, improvement is less likely following surgical or pharmacologically induced menopause, where the abrupt hormonal change can exacerbate symptoms.¹ In one clinic-based study, migraine worsened in 9% of women after spontaneous menopause, compared with 67% after surgical menopause, underscoring the importance of anticipatory guidance before procedures that induce menopause.¹⁸

This trajectory is not guaranteed, and improvement, when it occurs, may take years. As Dr. Lay notes, “there are women who will do everything right... and find that symptoms worsen during the perimenopausal and early menopausal years”. For those who do not improve, Dr. Pavlovic emphasises the need for proactive preventive management, including revisiting treatments that may not have been effective earlier in life.

Menopause should not be presented as a definitive resolution for migraine. Setting realistic expectations is a critical component of care.

Taken together, these findings reinforce that menstrual migraine is not a single phase condition, but a dynamic, hormone-driven disorder that evolves across the lifespan. From adolescence through reproductive years, pregnancy, perimenopause, and beyond, shifts in hormonal stability and withdrawal shape both the timing and severity of attacks. Yet care models and patient understanding often remain reactive rather than anticipatory. Recognizing these predictable transitions creates an opportunity for earlier identification, more informed decision-making, and proactive management strategies that evolve alongside a woman’s hormonal profile. Improving outcomes will depend not only on treatment, but on aligning care with the natural trajectory of the condition.

SECTION 6:

The Human Cost

The numbers in this survey do not reflect minor inconvenience. They reflect the repeated disruption of women's lives.

60% of respondents lose three or more days to migraine every menstrual cycle. At 12 cycles per year, that is more than 36 days annually — days of pain, reduced function, cancelled commitments, and recovery. For women who have lived with menstrual migraine for a decade or more, the cumulative total of days lived with limited functioning adds up to years of life impact.

Work and economic impact

In the past 12 months, menstrual migraine symptoms caused 71% of respondents to miss work or school. Nearly all respondents (97%) report reduced productivity during attacks, and notably, 29% say their productivity is *always* reduced when symptoms occur.

Migraine is already the leading cause of years lived with disability among women of reproductive age globally.² Menstrual migraine, with its predictable monthly recurrence and increased severity, represents a particularly concentrated form of this burden.

The impact is cumulative. For many women, symptoms occur over multiple days each month, translating to weeks of reduced productivity each year, sustained across decades of working life. The cost is not hypothetical. It is experienced repeatedly, month after month, during the years when workforce participation and career progression matter most.

IMPACT ON WORK

71%

miss work or school sometimes, often, or always because of menstrual migraine attacks

Source: National Women's Migraine Survey, 2026

Social and physical life impact

In the past 12 months, more than 8 in 10 respondents (85%) cancelled social plans because of menstrual migraine sometimes, often, or always. More than 9 in 10 women (92%) avoided physical activity at least sometimes, and 63% avoided it often or always.

These are not isolated episodes. They are recurring, monthly patterns that shape what women feel able to commit to, how they plan their lives, and how they are perceived by those around them. Over time, the impact extends beyond missed events to include lost opportunities for social connection, reduced self-care, and diminished participation in activities that support physical and mental wellbeing.

The dread ahead: mental health and the anticipatory burden

Perhaps the most under-recognized dimension of the burden is the anticipatory one. In the past 12 months, 4 in 5 respondents (80%) felt anxiety or dread about upcoming periods sometimes, often, or always. The attack itself causes disability. The knowledge that the attack is coming causes a different kind of harm: a recurring cloud over the days before menstruation that introduces burden beyond the individual migraine event.

Relationships and intimacy strained

More than half of respondents (55%) report having experienced strain in close relationships sometimes, often, or always in the past 12 months. This is not a secondary outcome. It connects directly to parenting, partnership, and social participation — and it compounds the clinical burden with a relational one that is not directly captured in clinical assessment.

The validation gap

Across open-ended responses, a clear and recurring theme is the experience of dismissal. Women describe having their symptoms minimised or attributed to “normal” menstrual changes, and report receiving generalized advice rather than menstrual migraine-specific care. Many describe identifying the hormonal pattern themselves, often after navigating multiple providers without a coordinated or targeted response.

“

“How very painful it is — and that people can’t be out of commission for 36 to 48 hours each month.”

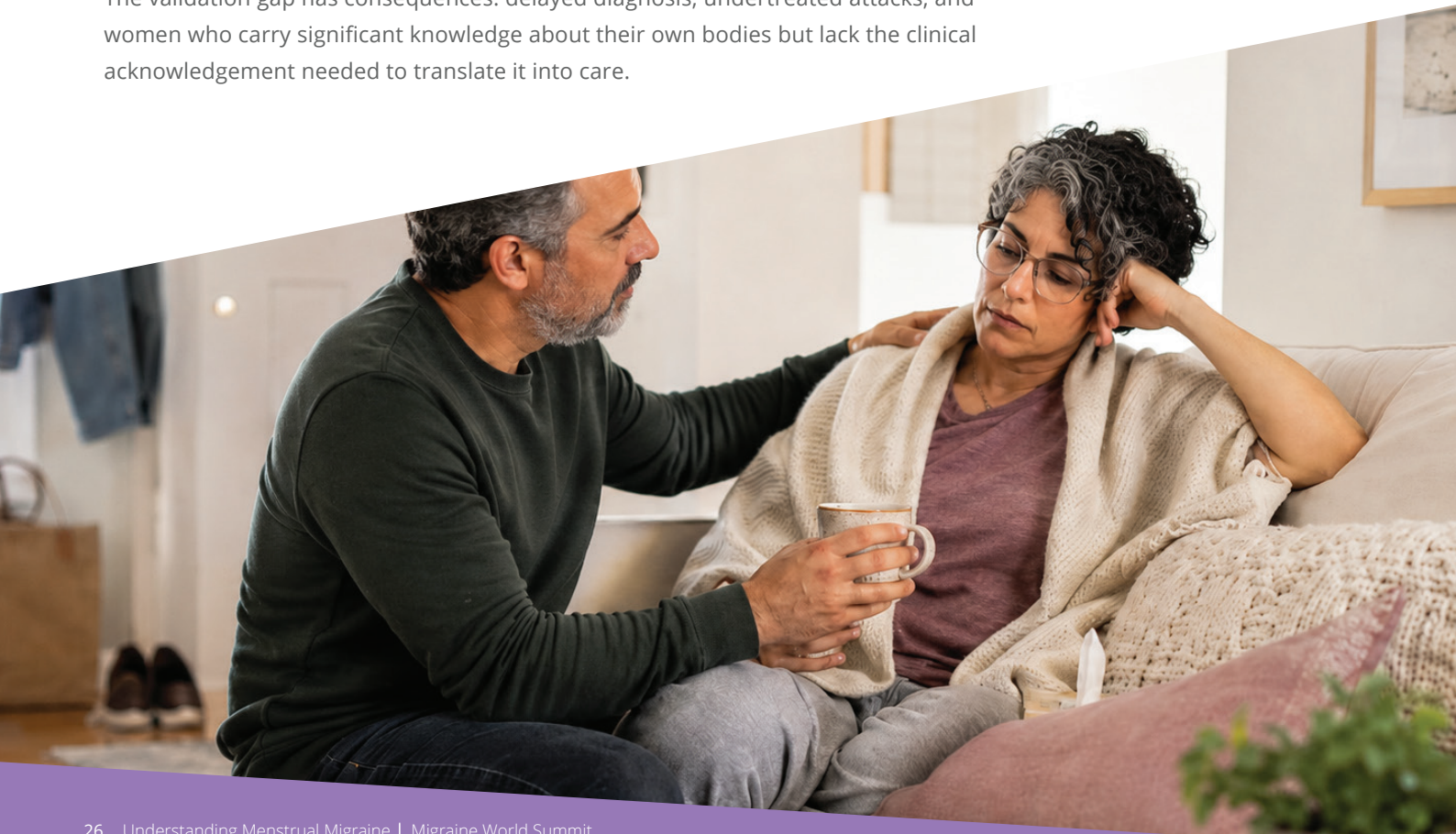
SURVEY RESPONDENT, AGE 47,
BEGAN EXPERIENCING MENSTRUAL
MIGRAINE AT AGE 18

“

*“It is REAL. My symptoms were dismissed for years.
I was told it was ‘all in my head’ or ‘just part of normal periods.’
This caused me to suffer physically and mentally.”*

— SURVEY RESPONDENT, AGE 40, BEGAN EXPERIENCING MIGRAINE AT AGE 17 —

The validation gap has consequences: delayed diagnosis, undertreated attacks, and women who carry significant knowledge about their own bodies but lack the clinical acknowledgement needed to translate it into care.



What Needs to Change

The findings in this report identify a clear and addressable set of gaps. The following priorities represent the most direct opportunities to improve outcomes for women with menstrual migraine.

Name the condition

The diagnosis gap is the first and most upstream problem. Without a specific diagnosis, targeted management is less likely. Women benefit from understanding that menstrual migraine is a recognized, named condition — not a set of symptoms to normalize or manage as undifferentiated migraine. Healthcare providers, across all specialties that support women with migraine, should routinely ask about the menstrual cycle and document the connection when it is present.

Unlock the predictability advantage

The most striking gap in this survey is between prediction and preparedness. If a woman knows her attacks are coming — as 96% of survey respondents do — she should be supported to act on that knowledge. Short-term prevention strategies deserve far wider clinical discussion. Women should know they exist. Providers should raise them routinely for women with predictable patterns. Not every woman will have a regular enough cycle for mini-prevention, but for those who do, the approach offers a direct, evidence-based path from forewarning to prevention.

Clarify the treatment landscape

Prescription acute treatments are widely used among respondents, yet many women continue to experience substantial disruption during menstrual migraine attacks, indicating that access alone is not the issue. Greater focus is needed on treatment optimization, including appropriate timing, combination approaches, and revisiting options that may not have been effective earlier.

Hormonal strategies may offer meaningful benefit for some women, particularly where stabilizing estrogen levels can reduce predictable attacks. However, these approaches are not appropriate for all, including women with migraine with aura, and require careful timing and clinical judgement. Practical considerations, such as continuous use of combined hormonal contraception to avoid estrogen withdrawal, may also play a role but are not consistently discussed.

Across both acute and hormonal approaches, the priority is not simply access, but informed, individualized care. Women who have stopped treatment due to limited effectiveness or safety concerns need clearer guidance, structured follow-up, and support to navigate evolving options over time. Prepare women for hormonal transitions.

Perimenopause represents one of the most significant escalation point for menstrual migraine, yet many women arrive at it entirely unprepared.^{2,4,5} The conversation about what perimenopause means for migraine should begin years before it arrives, not after it has already destabilized a previously managed condition. The same applies to pregnancy, postpartum, and contraception changes — each represents a foreseeable hormonal inflection point that can be anticipated and addressed.

“

“The unpredictable nature of perimenopause needs to be handled in years prior to its occurrence. Someone suffering from menstrual migraines should be prepared for the onset of perimenopause.”

— SURVEY RESPONDENT, AGE 45, BEGAN EXPERIENCING MENSTRUAL MIGRAINE AT AGE 25 —

Bridge the specialty gap

Menstrual migraine sits at the intersection of neurology, gynecology, and primary care. Most women are navigating these specialties in parallel, without coordination. Supporting women with clear guidance on what each provider can offer, and what questions to raise with each, is a practical form of empowerment that can close the coordination gap without requiring system-level change.

Reach women earlier

More than a third of respondents (37%) trace their menstrual migraine to adolescence (age 10 to 19), more than half of whom (51%) point to onset of menstruation as the prompt for menstrual migraine symptoms. An additional 27% of women who trace menstrual migraine back to their adolescent years could not identify a specific event or life stage that prompted their symptoms.

Earlier identification in primary care, pediatric settings, and initial OB/GYN visits could reduce years of undiagnosed and undertreated symptoms, and help establish more effective patterns of care from the outset.

Earlier intervention also has the potential to reduce cumulative disability over time, including during key education and early career years when the impact can be especially consequential.

A second critical education window occurs before women enter perimenopause and menopause. At this stage, evidence-based guidance on hormone therapy, surgical menopause, and migraine management may help women avoid preventable worsening and make more informed decisions that can affect their health and quality of life for years to come.

Address the aura subgroup

Women with migraine with aura face specific treatment constraints, particularly around combined hormonal contraception. Yet across the survey's open-ended responses, women with aura consistently raised the absence of guidance on alternatives — describing confusion, clinical rigidity, and reliance on self-directed research to fill the gap. This is a distinct clinical population whose informational needs are not currently being met in routine care.

Conclusion

Menstrual migraine is not a complaint to be managed around. It is a specific, clinically recognized condition with identifiable mechanisms, predictable timing, yet for many women, effective management remains out of reach. Only 34% of women in our study said their treatment was “very effective”.

The data from the National Women’s Migraine Survey makes clear that the majority of women living with it are receiving neither the diagnosis nor an effective treatment that their condition warrants.

The predictability paradox is the most telling finding in this report. 96% of women know their attacks are coming. Yet this forewarning is rarely translated into action. Most do not act on that knowledge, not because they lack motivation, but because they lack the support, the information, and the clinical recognition needed to prepare effectively.

This gap is reflected in care. More than 70% of respondents report they have never discussed short-term prevention strategies with a healthcare provider, despite the predictable nature of their attacks.

Addressing these gaps does not require new treatments or new technologies. It requires asking the right questions, naming what is present, offering evidence-based treatment strategies that already exist, and preparing women in young adulthood for the hormonal transitions that will shape their migraine across the full arc of their reproductive life.

The women in this survey are clear about what they need. They want to be heard. They want their condition taken seriously. They want management strategies that reflect the specific, predictable nature of menstrual migraine rather than treating it as undifferentiated pain.

That is a reasonable ask. It is also an achievable one.

ONLY

34%

of women in our study said their treatment was “very effective”.

Source: National Women’s Migraine Survey, 2026

Free resources for hormonal migraine

This whitepaper is part of a larger collection of free tools on hormones and migraine, including expert interview clips, a short course, and an email series.

Explore them all at www.migraineworldsummit.com/hormones-headache-hub

Notes

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About the Migraine World Summit

The Migraine World Summit is the world's largest free online event for people living with migraine. Each year, patient advocates interview over 30 of the world's leading migraine and headache experts. Over 10 years, more than 1.6 million migraine days have been prevented from Summit viewers. To learn more, visit migraineworldsummit.com.



About World Health Education Foundation

Since 2018, the World Health Education Foundation has been dedicated to serving those who live with chronic, disabling conditions to provide patients with affordable access to care, better education and advocacy. To learn more, visit worldhealtheducation.org.



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