SIGN 155: Pharmacological management of patients with migraine. Treatment pathway

Diagnosis

- Consider migraine in any patient presenting with episodic disabling headache.
- Patients with episodic disabling headache superimposed on a background of daily or near daily headache are likely to have chronic migraine.
- Always ask about acute medication use. If required for more than 2 days a week consider whether there may be medication overuse headache. Headache diaries can help.

Acute therapy

Avoid opiates and restrict acute medication to 2 days a week

- Simple analgesics: aspirin 900 mg or ibuprofen 400–600 mg
- Triptans:
  - sumatriptan 50–100 mg is first choice
  - all oral triptans are gastrically absorbed, so may not work if the patient is vomiting
  - triptans only work once headache starts
  - general efficacy is to work for 2 out of 3 attacks.

Early or persistent vomiting?

- Add antiemetic: metoclopramide 10 mg or prochloperazine 10 mg
- Consider nasal zolmitriptan or subcutaneous sumatriptan.

No response?

- Try other triptans
- Try triptan and NSAID combinations.

Lifestyle advice

For patients with migraine, maintaining a regular routine is important, including the following:

- Encourage regular meals, adequate hydration with water, sleep and exercise
- Avoid specific triggers if known
- Consider activities that encourage relaxation such as mindfulness, yoga or meditation.

Preventative therapy

- Consider if migraine is disabling and reducing quality of life, eg frequent attacks (>1 per week on average) or prolonged severe attacks.
- Which medication to try first depends on patient comorbidities, other health issues, drug interactions and patient preference.
- Anticonvulsants should be avoided in women who may become pregnant.
- Start at low dose and gradually increase according to efficacy and tolerability.
- Good response is a 50% reduction in severity and frequency of attacks.
- Treatment failure is a lack of response to the highest tolerated dose used for 3 months.

Therapies

- Propranolol: target dose 80 mg twice a day
- Topiramate: target dose 50 mg twice a day (use if propranolol fails) (women who may become pregnant require highly-effective contraception)
- Amitriptyline/other TCA: target dose 30–50 mg at night
- Candesartan: target dose 16 mg daily (avoid during pregnancy and breastfeeding).

Other options

- Sodium valproate target dose 600 mg twice a day (in patients over age 55)
- Pizotifen: target dose 3–4.5 mg (lacking evidence, but widely used).

Referral to neurology/headache clinic

Consider referral if three or more therapies have failed.

Treatment options include flunarazine, botulinum toxin A, or CGRP monoclonal antibodies.

Withdrawal

If the patient responds well to prophylactic treatment a trial of gradual drug withdrawal should be considered after six months to one year.

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