Primary care migraine treatment pathway for adults

Please provide patients with a daily headache diary to determine frequency and pattern.

Diagnostic criteria:

- Exclude secondary headaches. See NICE for further details and a list of red flags needing immediate action.
- Recurrent headache disorder (5 or more lifetime headache attacks), manifesting in attacks lasting **4-72 hours** (untreated or unsuccessfully treated).
- Typical characteristics of the headache are (at least two or more): **unilateral** location; **pulsating** quality; moderate or severe pain intensity; aggravation by routine **physical activity** and association with (at least one): **nausea/vomiting** and **photo/phonophobia**
- **Aura:** 25% of migraineurs experience aura (for at least some of their attacks). Recurrent attacks (more than 2), lasting minutes, of unilateral fully-reversible visual, sensory or other central nervous system symptoms that usually develop gradually and followed by headache and associated migraine symptoms.
- **Chronic migraine:** Headache 15 days/month of which ≥8 have migraine features (for more than 3 months)

Acute treatment:

Offer combination therapy (See NICE and BASH (p.23-26) for further guidance):

1st: simple analgesia + prokinetic antiemetic (**do not** prescribe opioids e.g. Co-codamol).

2nd: Triptans + simple analgesia + prokinetic antiemetic

Three different triptans should each be trialled on a minimum of two separate occasions, in line with the SEL Joint Medicines Formulary, before determining whether patient is a triptan non-responder (See overleaf). Triptans should not be taken on ≥10 days/month and simple analgesia on ≥15 days/month to **avoid** medication overuse headache.

Preventive treatment:

Consider a preventive treatment for patients if they:

- are taking analgesics for 2 or more days per week **OR** experience migraine symptoms on more than 4-5 days per month (for more than 3 months)
- experience less than 4-5 migraine days per month, but with poor response to acute treatment
- cannot take suitable acute treatment for migraine attacks due to contraindications or intolerance

Please consider when choosing a preventative treatment from the list below: patients past medical history, co-morbidities (including depression/anxiety/suicidal ideation), and whether they have child-bearing potential. **The order in which the treatments are chosen should be individualised to the patient based on the above.**

Side-effects are common with these medications, but often improve over time, please encourage patients to **titrate** the medication as tolerated/required (see BASH (page 28-29) for further guidance) and to take at least the **target dose** for a minimum of 3 months before determining effectiveness. We suggest reviewing treatment every six months. If effective consider tapering the dose after 6-12 months and advise patient to monitor for deterioration.

	Medication:	General considerations & contraindications:
GREEN	**Amitriptyline** ***Start:*** 10mg at night ***Target:*** 30-50mg at night ***Max:*** 100mg at night	See SmPC - Do not exceed 1mg/kg If unable to tolerate low dose amitriptyline consider **nortriptyline** (SmPC) with the same dosing guidance.
GREEN	**Propranolol (immediate release)** ***Start:*** 10mg twice daily ***Target:*** 40mg-80mg twice daily ***Max:*** 120mg twice daily	See SmPC Consider switching to a long-acting formulation once a maintenance dose is achieved.
AMBER 1	**Topiramate** ***Start:*** 25mg once daily ***Target:*** 50mg twice daily ***Max:*** 100mg twice daily	On specialist advice (consider using Advice & Guidance) See SmPC and MHRA advice on antiepileptic drugs in pregnancy – **Not recommended** in pregnancy and breastfeeding, ensure highly effective contraception.
GREEN	**Candesartan** ***Start:*** 4mg at night ***Target:*** 16mg at night ***Max:*** 32mg at night	See SmPC - **Not recommended** in pregnancy and caution in breastfeeding, ensure highly effective contraception. U&Es at baseline, three months and once yearly

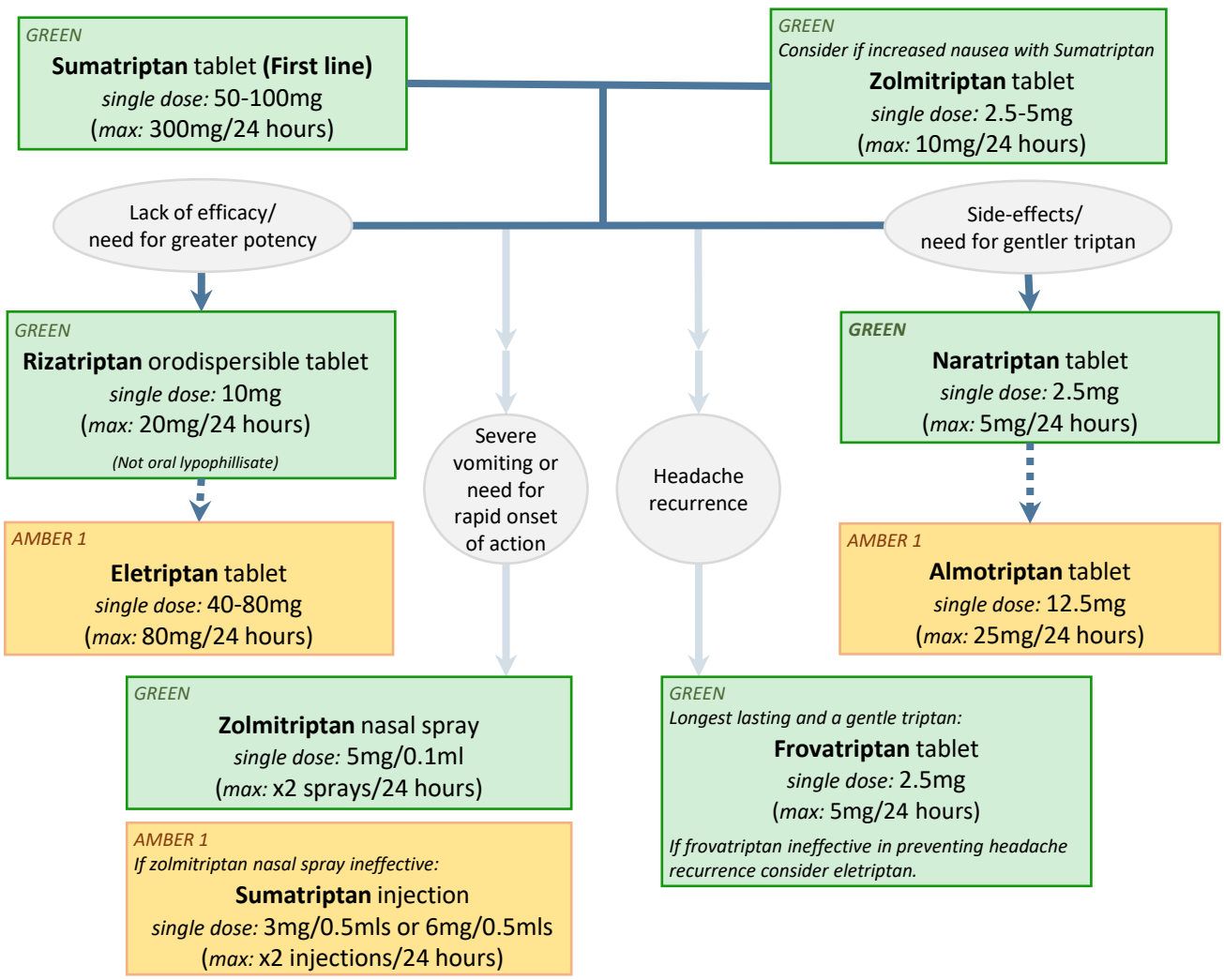
Refer to a specialist headache service for advice and consideration of further treatment when patients have exhausted the treatment options above due to ineffectiveness, tolerability and/or contraindications.
Specialist advice can also be obtained via Advice & Guidance (A&G).

Approval date: November 2023 **Review date: November 2025 (or sooner if evidence or practice changes)**

South East London Integrated Medicines Optimisation Committee (SEL IMOC). A partnership between NHS organisations in South East London Integrated Care System: SEL Integrated Care Board (covering the boroughs of Bexley/Bromley/Greenwich/ Lambeth/Lewisham and Southwark) and GSTFT/KCH /SLaM/ Oxleas NHS Foundation Trusts and Lewisham & Greenwich NHS Trust

Primary care migraine treatment pathway for adults: Triptan guidance

1. The below should be used in patients naïve to triptans or needing an alternative, do not amend existing prescriptions if effective and well tolerated. **The below should be read in conjunction** with the medications SmPC and the SEL Joint Medicines Formulary, please consider possible interactions. The **safety** of triptans in patients in older than 65 years has not been systematically evaluated and if possible, should be avoided. Contraindications include ischaemic heart disease, cerebrovascular disease, previous myocardial infarction and uncontrolled hypertension. Specialist advice can be obtained via Advice & Guidance (A&G) or referring to specialist headache services.
2. Triptans are used as an **acute treatment** of a migraine attack, most effective when taken early in the headache phase of an attack (see BASH for further info). Generally, if a patient has responded to the first dose of a triptan, but symptoms recur a second dose may be given, with a minimum 2-hour interval, not exceeding maximum dose in 24 hours. If the patient does not respond to the first dose of a triptan, a second dose is not advised for the same attack.
3. It is advisable that a patient tries a triptan on a **minimum of 2 separate occasions** prior to determining their response and should try three different triptans prior to determining patient is a triptan non-responder.
4. Headache **recurrence** refers to patients who consistently have a significant response to a triptan, but the headache rebounds or recurs and therefore a longer-lasting triptan may be more suitable to provide a more sustained response.



Other considerations:

1. Sumatriptan nasal spray has poor absorption and an unpleasant taste therefore has not been included in the above. However, it is the only licensed triptan (10mg/0.1ml) for 12–18-year-olds (outside scope of this guide).
2. Frovatriptan 2.5mg or zolmitriptan 2.5mg tablets should be considered (after NSAIDs) as preventative treatment **for menstrual migraine:** on the day's migraine is expected, generally from 2 days before until 3 days after (only suitable if cycle is regular/predictable). See NICE and BASH for further details.

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