Advice for management of Migraine/Chronic Headache for adult patients in primary care

Dept. Clinical Neurosciences, NHS Lothian, November 2024.

Please note this sheet is designed as a summary of headache pathways (based on NHS Scotland National Headache Pathway and SIGN 155). Please consult BNF or drug Summary of Product Characteristics for contraindications, cautions, side effects, *etc*.

Migraine and Chronic Daily Headache

These recommendations apply to episodic and chronic migraine. Most patients with chronic daily headache referred to neurology have underlying chronic migraine, which often coexists with medication overuse, sleep disturbance and fatigue.

General Lifestyle Advice

Common triggers: Sleep deprivation/excess, missing meals, exercise, stress (too much or relaxing after stress), minor neck/head injury, menstruation, alcohol. Useful advice available at The Migraine Trust, or the Headache Relief Guide (interactive tools built for teenagers, but good for adults too). Sleep management (prescribe 'Sleepio' app for free in NHS Scotland), aerobic exercise and psychological therapies help some.

Acute Treatment – have you provided adequate trials of different acute treatments?

All acute treatments work better if taken earlier in the headache and combined with sleep when possible.

Mild to moderate	Moderate to severe	Add antiemetic if significant nausea
Paracetamol 1000mg	Sumatriptan 50-100mg	Prochlorperazine 10mg (also has an analgesic effect)
Aspirin 900mg	Try other formulary triptans if Sumatriptan ineffective: Almotriptan, Rizatriptan or Frovatriptan (longer half-life).	Metoclopramide 10mg (prokinetic effects useful)
Ibuprofen 400-600mg	Consider other routes of administration if significant nausea or vomiting, *i.e.* nasal Zolmitriptan 5mg, subcut Sumatriptan 6mg	Antiemetics should be used short term to reduce risk of side effects
Naproxen 500mg	Rimegepant 75mg daily can be considered for patients not responding to ≥2 triptans, or if triptans contraindicated	

Avoid opioids – less effective and significant risk of medication overuse headache.
Any triptan can be used in combination with NSAID or Aspirin, if triptan alone does not give sufficient relief.

Medication overuse: Medication overuse headache is common in patients with chronic daily headache/frequent migraine. Give acute treatments no more than 10 days per month. Regular daily analgesia should be stopped and the patient warned to expect worse headache for 1-3 weeks before they may notice any improvement.

Prophylaxis – have you provided adequate trials of different prophylactic treatments?

Prophylaxis should be considered when patients are overusing acute treatments, or headaches interfere with social or occupational functioning. Patients must be counselled that prophylaxis aims to **reduce the frequency and/or severity** of attacks, not abolish them completely; a reduction of 30% in either frequency or severity is a positive response. Patients should be warned to expect some side effects, particularly initially, and **use each treatment for at least 8 weeks after reaching maximal tolerable dose,** before deciding if a treatment is effective. Slower titrations may improve tolerability, and some minor side effects may improve after a period.

Medication	Amitriptyline	Candesartan	Propranolol	Topiramate
Starting dose	10mg nocte If excess drowsiness, try a less sedating tricyclic *e.g.* Nortriptyline	2-4mg OD Check baseline Cr&E	10-20mg BD	25mg nocte **NB: Contraindicated in women of childbearing potential unless pregnancy prevention programme in place**
Suggested increment	10mg every 1-2 weeks	2-4mg every 1-2 weeks Check Cr&E intermittently	10-20mg BD every 1-2 weeks	25mg every 1-2 weeks
Target dose (or highest tolerated)	50mg nocte If partially effective and well tolerated, further up titration possible to 100mg	16mg OD (or 8mg BD)	80mg BD	50mg BD If partially effective and well tolerated, further up titration possible to 100mg BD

Gepants: can be prescribed for prevention of episodic or chronic migraine in primary care if patients have more than 10 moderate/severe migraine days per month and have not responded to three preventative agents.
Atogepant 60mg daily: for episodic or chronic migraine. **Rimegepant** 75mg every other day: for episodic migraine.

Botox and CGRP monoclonal antibody drugs (erenumab, fremanezumab and galcanezumab) are available for eligible patients who are referred to secondary care headache clinics.

Pregnancy: Migraine will often improve during pregnancy, but not for all patients. Maximise lifestyle advice. See separate RefHelp page for guidance on therapies for management. Most migraine treatments require caution, or are contraindicated, in pregnancy.

Open access CT brain scan: NHS Lothian offers open access CT head scan. Evidence suggests that CT head has no long-lasting reassuring effect in patients worried about their headache. Consider the 10% rate of incidental findings, negligible chance of a relevant finding in a patient with migraine, radiation dose and resource implications of a CT head scan.

Referral to Neurology: Referral via the 'Chronic Headache' pathway on SCI gateway is for patients where the diagnosis is uncertain, or for patients who have more than 10 moderate/severe days or severely interfering migraine, tried ≥3 prophylactic medications each for a period of 8 weeks at therapeutic doses (if tolerated). Gepants may be started in primary care prior to referral if indicated.