

Migraine advice for adult patients in primary care

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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.

CRITERIA FOR HEADACHE CLINIC REFERRAL:

- Migraine that is **interfering with social or occupational functioning or where moderate/severe headache days are more than 10 days a month.**
- Unsuccessful trials of **at least three first-line prevention agents (tricyclic, propranolol, candesartan – or topiramate if male)** for at least 8 weeks, expecting reduction, not cessation, of migraine.
- **Consideration of a trial of a second-line prevention agent (Atogepant or Rimegepant)** which can be initiated in primary care (a trial is not a prerequisite)

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 [Migraine | NHS inform](#). Sleep management (prescribe '[Sleepio](#)' app for free in NHS Scotland), aerobic exercise and psychological therapies help some.

ACUTE TREATMENT

All acute treatments work better if taken earlier in the headache and combined with sleep when possible. Use acute treatments no more than 10 times a month (except Rimegepant, which can be used up to 15 times)

Mild to Moderate Migraine	Paracetamol 1000mg; or Aspirin 900mg; or Ibuprofen 400–600mg; or Naproxen 500mg
Moderate to Severe Migraine	Sumatriptan 50–100mg If ineffective: Almotriptan 12.5mg, Rizatriptan 10mg or Frovatriptan 2.5mg If significant nausea/vomiting, consider: nasal Zolmitriptan 5mg, subcutaneous Sumatriptan 6mg Rimegepant 75 mg PRN if no response to ≥ 2 triptans, or if triptans are contraindicated

- **Add antiemetic** if significant nausea. Prochlorperazine 10mg (also has an analgesic effect) Metoclopramide 10mg (prokinetic effects useful). Use short-term to reduce risk of side effects
- **Avoid opioids** – less effective and significant risk of medication overuse headache.
- 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 should be warned to expect worse headache for 1-3 weeks before they may notice any improvement.

PREVENTION (PROPHYLAXIS)

Prophylaxis should be considered when

- There are 4 or more moderate or severe headache days a month **OR**
- Patients are overusing acute treatments **OR**
- Headaches interfere with social or occupational functioning

Prophylaxis aims to **reduce the frequency and/or severity** of attacks, not abolish them completely, e.g. reduction of 30-50% in frequency and/or severity.

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.

FIRST LINE PREVENTION TREATMENTS

Medication	Starting dose	Suggested increment	Target dose	Notes
Nortriptyline/ Amitriptyline	10mg nocte	10mg every 1-2 weeks	50mg nocte	Can go up to 100mg nocte. Slower titrations might be better tolerated if side effects
Candesartan	2-4mg OD	2-4mg every 1-2 weeks	16mg OD (or 8mg BD)	Check baseline U&E and intermittently during titration.
Propranolol	10-20mg BD	10-20mg BD every 1-2 weeks	80mg BD	Consider contraindications such as asthma, bradycardia or hypotension.

Topiramate, taken as 25mg nocte, increasing by 25mg every 1-2 weeks aiming for 50mg BD is contraindicated in women of childbearing potential unless a Pregnancy Prevention Programme is in place. If partially effective and well tolerated, further up-titration possible to 100mg BD. We now avoid it in most individuals due to theoretical risks to men as well.

SECOND LINE PREVENTION TREATMENTS – if no response to first line treatment

Medication	Starting dose	Notes
Rimegepant	75mg every other day (for episodic migraine, <15 headache days/month)	Constipation or loss of appetite can be an issue when starting, but usually settles down after 2-3 weeks, effect can take up to 4-6 months to happen
Atogepant	60mg daily (for episodic and chronic migraine)	

HEADACHE CLINIC for HOSPITAL-ONLY TREATMENTS

CGRP monoclonal antibody drugs (Erenumab, Fremanezumab and Galcanezumab) for chronic migraine are available for eligible patients who are referred to secondary care headache clinics. These work on a similar pathway to Rimegepant and Atogepant. **Botulinum Toxin injections** for chronic migraine are available to selected patients seen in the Headache clinic.

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. More information at Refhelp (link).

CT HEAD SCANS

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

Who to refer:

- Patients meeting migraine referral criteria in the box at the top of this document

Information to include in referral

- Number of headache days per month (number of moderate/severe if known)
- Preventer medications tried, dose and duration of trial.

Who not to refer:

- Patients with episodic migraine which is not interfering with social or occupational functioning
- Patients who have not been through acute treatment, at least three first-line treatments (where possible), and where you haven't considered a trial of Atogepant or Rimegepant (but not mandatory).
- Patients where you haven't yet attempted to address medication overuse headache (noting that the presence of medication overuse headache is not a barrier to referral)