Chronic Migraine Pathway for adults

3Ts Formulary
Swindon CCG & Wiltshire CCG
Great Western Hospitals NHS Foundation

Primary Care diagnosis of chronic migraine

- Diagnosis based on history & normal physical examination
- Ensure no medication overuse* (see notes below & references for further info)
- >15 headache days/ month, for at least 3 months of which 8 migrainous.
- Encourage patient to keep headache diary* (see overleaf)
- Lifestyle changes including avoidance of trigger factors (see overleaf)

Primary care treatment of chronic migraine

Prophylactic medication (3 options must be tried before referral for Botox):

Propranolol LA 80 mg od -160mg bd or **atenolol** 25mg od increasing to 50mg od (both unlicensed, atenolol may be better tolerated but not included in NICE CG150) **OR**

Topiramate* Initially 25mg ON for 1/52 then increase by 25mg/wk; usual dose 50-100mg daily in 2 divided doses; max 200mg od. Local consultants advise to start at low doses (e.g. 15mg od) & titrate slowly (due to risk of side effects) to maintenance of 50mg bd. **Before the initiation of treatment with topiramate in a woman of childbearing potential, pregnancy testing should be performed and a highly effective contraceptive method advised.** The patient should be fully informed of the risks related to the use of topiramate during pregnancy. See further information overleaf.

Consider Amitriptyline Initially 10mg nocte then increased if necessary to 50-75mg nocte (max 150mg ON). Useful if migraine co-exists with depression, disturbed sleep, chronic pain condition or troublesome tension-type headache. Not licensed for migraine prophylaxis.

Trial at maximum tolerated dose for 6-8 weeks.

Review the need for continuing migraine prophylaxis 6 months after the start of prophylactic treatment if effective.

Acute medication: Triptans (see formulary) up to 6 days/month; NSAID/paracetamol up to 10 days/month.

Accupuncture is recommended by NICE for chronic tension type headache as an option if both topiramate and propranolol are unsuitable or ineffective. This is not available on the NHS locally (IFR route only).

Patient referred to Consultant Neurologist.

GP refers patient with difficult to treat headache or where diagnosis is uncertain for 2nd opinion. Most patients will be referred back to GP after one consultation. The consultant will consider one of the following options with the patient.

Other specialist prophylactic medication options

Greater Occipital Nerve block (GON)

Botox Injection
(not available from SFT)

Consider pain clinic referral

Medication Overuse Headache

Be alert to the possibility of medication overuse headache in people whose headache developed or worsened while they were taking the following drugs for 3 months or more:

- Triptans, opioids, ergots or combination analgesic medications on 10 days per month or more or
- Paracetamol, aspirin or an NSAID, either alone or any combination, on 15 days per month or more.

Patients should be advised to stop taking all overused acute headache medications for at least 1 month and to stop abruptly rather than gradually. Provide patients with close follow-up and support according to their needs. Consider specialist referral &/or inpatient withdrawal of overused medication for people who are using strong opioids, or have relevant comorbidities, or in whom previous repeated attempts at withdrawal have been unsuccessful.

Review the diagnosis of Medication Overuse Headache and further management 4-8 wks after the start of withdrawal of overused medicines.

NOTES

***Topiramate:**

Advise women and girls of childbearing potential that topiramate is associated with a risk of fetal malformations. Ensure they are offered highly effective contraception. Topiramate is an enzyme-inducer and can reduce the efficacy of hormonal contraception. Patients taking oestrogen containing contraceptives should be asked to report any change in their bleeding patterns. See SPC for detailed information: https://www.medicines.org.uk/emc/product/1982/smpc

Menstrual-related migraine

For women and girls with predictable menstrual-related migraine that does not respond adequately to standard acute treatment, consider treatment with frovatriptan (2.5 mg twice a day) or zolmitriptan (2.5 mg twice or three times a day) on the days migraine is expected.

Treatment of migraine during pregnancy

Offer pregnant women paracetamol for the acute treatment of migraine. Consider the use of a triptan or an NSAID after discussing the woman's need for treatment and the risks associated with the use of each medication during pregnancy.

Seek specialist advice if prophylactic treatment for migraine is needed during pregnancy.

Headache Diary:

Encourage the use of a headache diary & stress management. Use a headache diary to record the frequency, duration & severity of headaches, to monitor the effectiveness of headache interventions & to use as a basis for discussion with the patient about their headaches. Useful headache diaries can be found here: https://www.migrainetrust.org/living-with-migraine/coping-managing/keeping-a-migraine-diary/ and https://www.migrainetrust.org/wp-content/uploads/2015/11/FS05aMigraineDiaries.pdf

General Lifestyle advice:

- Regular meals (avoid snack foods and missing meals) and stay hydrated. Dehydration is a risk factor for migraines.
- Avoid excess alcohol, fizzy drinks
- Regular sleep and daily aerobic exercise (walking, cycling)
- Avoid specific triggers (glare, stress, foods, drinks, travel)

Patient support group:

- Migraine Trust Helpline: 020 7631 6970 www.migrainetrust.org

Useful references:

1.) Diagnosis and management of headaches in young people and adults. NICE CG150 September 2012 (prophylaxis section updated Nov 2015). https://www.nice.org.uk/guidance/cg150

2.) BASH (2010) *Guidelines for all healthcare professionals in the diagnosis and management of migraine, tension-type, cluster and medication-overuse headache.* British Association for the Study of Headache.3rd Edition http://www.bash.org.uk/guidelines/

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