Management of Patients with Migraine

Treatment of Acute Migraine Attacks:
Most acute attacks respond to simple analgesics such as Paracetamol or NSAIDs.

Clinical trials continue to show **Ibuprofen** to be effective in managing acute migraine attacks, at a dose of 400mg to 600mg every 4 to 6 hours to a maximum of 2.4g in 24 hours. See also Section 10.1.1 for advice on prescribing NSAIDs.

Soluble tablets or liquids are most effective because peristalsis is often reduced during migraine attacks.

Metoclopramide or Domperidone are the anti-emetics of choice. A short course is only needed.

Sumatriptan should be reserved for acute attacks where simple analgesia has not worked, or for patients that have responded well to 'triptans' previously. **Zolmitriptan** is available as a second line alternative. Triptans are more effective if taken with paracetamol and/or NSAIDs

Sumatriptan is given as a single dose of 50mg (100mg may be required in some patients). **Zolmitriptan** is given as a single dose of 2.5mg, although a 5mg dose is available for those not achieving satisfactory response with the 2.5mg dose. Patients not responding should not take a second dose for the same attack.

Sumatriptan and **zolmitriptan** are contraindicated in ischaemic heart disease, previous myocardial infarction, coronary vasospasm (including Prinzmetal's angina), uncontrolled or severe hypertension, peripheral vascular disease, previous stroke or TIA. Zolmitriptan is contraindicated in patients with Wolff-Parkinson-White syndrome or arrhythmias associated with accessory cardiac conduction pathways

Prophylaxis of Migraine:
Discuss the benefits and risks of prophylactic treatment for migraine with the person, taking into account the person's preference, comorbidities, risk of adverse events and the impact of the headache on their quality of life. Prophylaxis is recommended if attacks are frequent (i.e. two or more attacks per month)

Topiramate this is given 25mg daily and can be titrated to 50mg twice daily. (*Tablet formulation is preferred as significantly cost-effective*). Women and girls of childbearing potential should be counselled that topiramate is associated with a risk of foetal malformations and can impair the effectiveness of hormonal contraceptives. Women and girls of child bearing age need to be offered appropriate suitable contraception.

Propranolol should be given as an initial dose of 40mg twice a day, with a maintenance dose of 80 to 160mg daily in divided doses. Modified release preparations may cause fewer side effects (i.e. or 80-160mg MR once daily).

Amitriptyline is given in similar doses to those used to treat neuropathic pain. Suggest starting dose of 10mg at night with increase in 10mg increments up to 100mg once a day.

If topiramate, propranolol and amitriptyline are unsuitable or ineffective, consider a course of up to 10 sessions of acupuncture over 5–8 weeks or gabapentin (up to 1200 mg per day) according to the person's preference, comorbidities and risk of adverse events.