KISS: Management of Migraine

Based on: NEJM2017;377;553 SIGN 155, 2018 BASH 2019

Triggers/exacerbating factors:

- Many potential triggers but evidence for trigger avoidance limited
- Review **medications that may be contributory**:
  - Oestrogen containing contraceptives, PPIs, SSRIs have been associated
  - Review **acute medication use -** 2/3 chronic migraine sufferers have evidence of medication overuse; if taking acute medications on ≥2 days/week at risk of medication overuse headache

Acute treatment:

- Take a flexible approach depending on severity; options include:
  - **Aspirin** 900mg, other **NSAID** (e.g. ibuprofen 400-600mg); **adding anti-emetics** (e.g. prochlorperazine 10mg, metoclopramide 10mg) improves effectiveness even in the absence of nausea and vomiting (improves gastric motility/drug absorption)
  - **Triptans:**
    - Lack of effect at 2 hours = treatment failure; lack of response to one triptan does not predict response to other triptans so try alternatives (or different delivery mode) if 2 treatment failures
    - Combining long-acting NSAID (e.g. naproxen) with triptan is more effective than triptan monotherapy
    - **Take early in the HEADACHE phase, not the aura phase**
- Do NOT use opioids - generally ineffective and high risk of medication overuse headache

Prophylaxis:

- **Consider preventative treatment if ≥ 4 migraines/month**, but take a **flexible approach** depending on both severity as well as the frequency of attacks, as well considering **individualised treatment** depending on co-morbidities (e.g. amitriptyline if insomnia etc.)
- Titrate slowly to maximum effective tolerated dose for minimum 6-8 weeks before deciding on effectiveness (ideally with headache diary)
- Consider gradual withdrawal after 6-12 months of effective treatment.
- **Recommended drug treatments:**
  - Propranolol 10-20mg BD, up to max 120-240mg/day
  - Amitriptyline 10-150mg ON
  - Topiramate 25mg OD to max 100mg BD
  - Candesartan 2mg OD to max 8mg BD
- NICE (TA 631 June 2020) have recently approved fremanezumab as an option for people with chronic migraine AND when at least 3 preventive drug treatments have failed
- There is also evidence for other drugs including lisinopril, sodium valproate and other beta-blockers (metoprolol, timolol, atenolol); Note that **gabapentin is NOT effective** and should not be offered
- **Supplements**: Co-enzyme Q10 (150mg/day), Magnesium (400-600mg/day), Riboflavin (400mg/day)
- **Non-drug treatment**:
  - Acupuncture (10 sessions) is recommended as an option (including by NICE)
  - CBT added to drug therapy can reduce migraine-associated disability
- **Menstrual migraine**:
  - Consider short term preventative strategy - Zolmitriptan 2.5mg BD/TDS or frovatriptan 2.5mg BD for 2 days before until 3 days after bleeding starts

Patient information NHS Choices: Migraine triggers and Migraine Trust, Coping with migraine