BSW Chronic Migraine Pathway for adults

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group

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 options – NICE CG150[1] recommended

Propranolol LA 80mg -240mg od or **atenolol** 25mg od increasing to 50mg od (atenolol may be better tolerated but unlicensed for this indication and not included in NICE CG150) **OR**

Topiramate* Licensed dose: 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 initiation in females with childbearing potential, pregnancy testing should be performed and a highly effective contraceptive method advised. See further information overleaf.

Consider Amitriptyline 10-70mg nocte. Useful if migraine co-exists with depression, disturbed sleep, chronic pain condition or troublesome tension-type headache. **HIGHLY ANTICHOLINERGIC**; avoid in >65yrs and frail. Inform of risk of serious side effects incl. cognitive impairment. Stop if not effective.

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.

Acupuncture – see Page 2

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 prophylactic medication options not in CG150 but supported by BASH[2] UK Guidelines. Specialist initiation only.

Candesartan (unlic) 2mg OD incr. by 2mg weekly if needed to max 8mg BD.

****Sodium Valproate** (unlic) 200 mg BD incr. if needed to 1.2–1.5 g daily in divided doses. See P2

Not recommended locally for use in women of child-bearing age

Greater Occipital Nerve block (GON)

Botox Injection - 3 prophylactic options must be tried before referral for Botox

Erenumab (Aimovig®), galcanezumab (Emgality®) and fremanezumab (Ajovy®) are **RED TLS drugs** for use in line with NICE (TA682, TA659, TA631 respectively) and in line with BSW biologic migraine prevention Blueteq pathway

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 close follow-up and support according to need. 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.

***Topiramate**

Advise females 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.

****Valproate**

HIGH TERATOGENIC RISK. Valproate must only be used in females if there is a pregnancy prevention programme (PPP) in place. See MHRA link and risk minimisation materials here. **Unlicensed use of sodium valproate for migraine prophylaxis is not supported locally for females of child-bearing age.**

Pizotifen

Pizotifen is not included in this pathway. Inadequate evidence was found in the review for NICE CG150 for the effectiveness of pizotifen in the prophylaxis of migraine in adults.

Flunarazine

Flunarazine is an unlicensed medicine included for use on a named patient basis only. This is a RED traffic light drug and prescribing and supplies of medication from secondary care specialist only.

Acupuncture

Acupuncture is recommended for chronic migraine as per NICE CG150 but is not locally commissioned. Patients should self-purchase acupuncture treatment or a specialist may consider an IFR if the patient is exceptional.

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 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 migraine treatment is needed during pregnancy. UK Teratology Information Service (UKTIS) can be contacted by healthcare professionals on 0344 892 0909. A UKTIS patient leaflet on Treatment of Migraine in Pregnancy can be accessed here.

Headache Diary:

Encourage the use of a headache diary and stress management. Use a diary to record the frequency, duration and severity of headaches, to monitor the effectiveness of headache interventions and to use as a basis for discussion with the patient about their headaches. The Migraine Trust have diaries that can be found here.

General Lifestyle advice:

- Regular meals (avoid snack foods and missing meals). Avoid excess alcohol, fizzy drinks.
- Regular sleep and daily aerobic exercise (walking, cycling).
- Avoid specific triggers (glare, stress, foods, drinks, travel).
- UK Guidelines advise that riboflavin 400mg OD may be useful in preventing migraines[2,3]. This recommendation refers to **self-purchase only from reputable health food shops.** There is no licensed riboflavin product in the UK and prescribing on FP10 may incur costs of up to £500 per item. Larger, robust trials are required to conclusively establish its role in migraine prevention.

Patient support groups:

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

gammaCore:

- gammaCore (electroCore) is a medical device that uses non-invasive vagus nerve stimulation to treat and prevent cluster headaches. It is **not commissioned for migraine** and commissioned only for cluster headaches in line with NICE MTG46.

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 (2019) British Association for the Study of Headache. National Headache management System for Adults 2019. www.bash.org.uk
3.) UKMI Q&A (2017) Can riboflavin reduce the incidence of migraines in adults? https://www.sps.nhs.uk/articles/can-riboflavin-reduce-the-incidence-of-migraines-in-adults/