Healthcare Improvement Scotland | SIGN

SIGN 155

Pharmacological management of migraine

Quick reference guide

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This Quick Reference Guide provides a summary of the main recommendations in **SIGN 155 Pharmacological management of migraine**.

Recommendations **R** are worded to indicate the strength of the supporting evidence. Good practice points ✓ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**.

ACUTE THERAPIES

✓ When starting acute treatment, healthcare professionals should warn patients about the risk of developing medication-overuse headache.

ASPIRIN

R **Aspirin** (900 mg) **is recommended as first-line treatment for patients with acute migraine.**

✓ Aspirin, in doses for migraine, is not an analgesic of choice during pregnancy and should not be used in the third trimester of pregnancy.

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

R **Ibuprofen** (400 mg) **is recommended as first-line treatment for patients with acute migraine. If ineffective, the dose should be increased to 600 mg.**

✓ During pregnancy, ibuprofen should be used with caution and only up to 20 weeks, if paracetamol or sumatriptan, or a combination of both, are ineffective in reducing pain.

PARACETAMOL

R **Paracetamol** (1,000 mg) **can be considered for treatment of patients with acute migraine who are unable to take other acute therapies.**

✓ Due to its safety profile, paracetamol is first choice for the short-term relief of mild to moderate headache during any trimester of pregnancy.

ANTIEMETICS

R **Metoclopramide** (10 mg) **or prochlorperazine** (10 mg) **can be considered in the treatment of headache in patients with acute migraine. They can be used either as an oral or parenteral formulation depending on presentation and setting.**

R **Metoclopramide** (10 mg) **or prochlorperazine** (10 mg) **should be considered for patients presenting with migraine-associated symptoms of nausea or vomiting. They can be used either as an oral or parenteral formulation depending on presentation and setting.**

✓ Metoclopramide should not be used regularly due to the risk of extrapyramidal side effects.

TRIPTANS

R **Triptans are recommended as first-line treatment for patients with acute migraine.**

R **In patients with severe acute migraine or early vomiting, nasal zolmitriptan or subcutaneous sumatriptan should be considered.**

R **Triptans are recommended for the treatment of patients with acute migraine associated with menstruation.**

R **Sumatriptan can be considered for treatment of acute migraine in pregnant women in all stages of pregnancy.**

✓ Triptans should not be used in patients at high risk of ischaemic cardiovascular disease, including uncontrolled hypertension.

ORAL CALCITONIN GENE-RELATED PEPTIDE RECEPTOR ANTAGONISTS

R **Rimegepant should be considered for patients with acute migraine who have had an inadequate response or poor tolerability to two or more triptans, and paracetamol or NSAIDS have been considered to be ineffective or unsuitable.**

R **Rimegepant can be considered for patients with acute migraine who have contraindications to triptans.**

✓ Careful consideration should be given to the potential risks and benefits for patients at high risk of ischaemic cardiovascular disease, including uncontrolled hypertension, before prescribing oral CGRP receptor antagonists.

✓ Use of rimegepant should be avoided in pregnancy and breastfeeding due to insufficient safety data.

COMBINATION THERAPIES

R **Co-prescription of sumatriptan and naproxen should be considered for the treatment of patients with acute migraine.**

✓ A combination of a triptan with a non-steroidal agent and/or an antiemetic can be considered for the treatment of patients with acute migraine.

PREVENTATIVE THERAPIES

CANDESARTAN

R **Candesartan** (16 mg daily) **can be considered as a prophylactic treatment for patients with episodic or chronic migraine.**

R **Use of candesartan should be avoided during pregnancy and breastfeeding. Women using candesartan who are planning to become pregnant, or who are pregnant, should seek advice from their healthcare professional on switching to another therapy.**

BETA BLOCKERS

R **Propranolol** (80–160 mg daily) **is recommended as a first-line prophylactic treatment for patients with episodic or chronic migraine.**

TRICYCLIC ANTIDEPRESSANTS

R **Amitriptyline** (25–150 mg at night) **should be considered as a prophylactic treatment for patients with episodic or chronic migraine.**

R **In patients who cannot tolerate amitriptyline a less sedating tricyclic antidepressant should be considered.**

ORAL CALCITONIN GENE-RELATED PEPTIDE RECEPTOR ANTAGONISTS

R **Atogepant is recommended for the prophylactic treatment of patients with episodic or chronic migraine who have at least four migraine days per month, where medication overuse headache has been addressed and patients have not benefitted from appropriate trials of three or more oral migraine prophylactic treatments.**

R **Rimegepant is recommended for the prophylactic treatment of patients with episodic migraine** (4 to 14 days per month)**, where medication overuse headache has been addressed and patients have not benefitted from appropriate trials of three or more oral migraine prophylactic treatments.**

✓ Careful consideration should be given to the potential risks and benefits for patients at high risk of ischaemic cardiovascular disease, including uncontrolled hypertension, before prescribing oral CGRP receptor antagonists.

✓ Use of atogepant or rimegepant should be avoided during pregnancy and breastfeeding. A washout period of at least 1 week is advised before trying for a pregnancy.

✓ Medication overuse headache should be addressed before treatment with atogepant or rimegepant, however, in patients where treatment of medication overuse headache has been unsuccessful, atogepant or rimegepant can still be considered.

BOTULINUM TOXIN A

R **Botulinum toxin A is not recommended for the prophylactic treatment of patients with episodic migraine.**

R **Botulinum toxin A is recommended for the prophylactic treatment of patients with chronic migraine where medication overuse has been addressed and patients have been appropriately treated with three or more oral migraine prophylactic treatments.**

✓ Botulinum toxin A should only be administered by appropriately trained individuals under the supervision of a headache clinic or the local neurology service.

CALCITONIN GENE-RELATED PEPTIDE MONOCLONAL ANTIBODIES

R **Erenumab, fremanezumab, galcanezumab and eptinezumab are recommended for the prophylactic treatment of patients with chronic migraine where medication overuse has been addressed and patients have not benefitted from appropriate trials of three or more oral migraine prophylactic treatments.**

R **Fremanezumab, galcenezumab and eptinezumab can be considered for the prophylactic treatment of patients with episodic migraine where medication overuse has been addressed and patients have not benefitted from appropriate trials of three or more oral migraine prophylactic treatments.**

✓ There should be careful consideration of potential risks and benefits to patients at high risk of ischaemic cardiovascular disease before prescribing CGRP monoclonal antibodies.

✓ When initiating CGRP monoclonal antibodies, it is reasonable to measure blood pressure before treatment initiation, and periodically thereafter. Treatment with these agents in patients with uncontrolled hypertension is cautioned.

✓ Use of CGRP monoclonal antibodies should be avoided during pregnancy and breastfeeding. A washout period of 6 months is advised before trying for a pregnancy.

✓ Medication overuse headache should be addressed before treatment with CGRPs. However, in patients where treatment of MOH has been unsuccessful, CGRP monoclonal antibodies should still be considered.

TOPIRAMATE

CHECK CURRENT MHRA ADVICE

R **Topiramate** (50–100 mg daily) **can be considered as a prophylactic treatment for patients with episodic or chronic migraine. It should not be prescribed in women of childbearing potential unless the conditions of a pregnancy prevention programme are fulfilled.**

R **Prescribers should be aware that topiramate is associated with an increased risk of serious developmental disorders, congenital malformations and low birth weight in children exposed to topiramate in utero. For women who may become pregnant, topiramate should only be considered as a prophylactic treatment when:**

- **other treatment options have been exhausted**
- **patients are using contraception in line with the MHRA Topiramate Pregnancy Prevention Programme.**

Before commencing treatment, women should be informed of:

- **the risks associated with taking topiramate during pregnancy**
- **the risk that potentially harmful exposure to topiramate may occur before a woman is aware she is pregnant**

- **the need to use effective contraception**
- **the need to seek urgent advice on migraine prophylaxis and stopping topiramate if planning a pregnancy**
- **the need to stop taking topiramate (for migraine prevention) straight away if they do become pregnant and contact their GP.**

✓ A washout period of at least 4 weeks after the last dose of topiramate is advised before trying for a pregnancy.

✓ Topiramate should not be used during breastfeeding.

CALCIUM CHANNEL BLOCKERS

R **Flunarizine** (10 mg daily) **should be considered as a prophylactic treatment for patients with episodic or chronic migraine.**

✓ Use of flunarazine should be avoided during pregnancy and breastfeeding. Women using flunarazine who are planning to become pregnant, or who are pregnant, should seek advice from their healthcare professional on switching to another therapy.

SODIUM VALPROATE

CHECK CURRENT MHRA ADVICE

R **Sodium valproate** (400–1500 mg daily) **can be considered as a prophylactic treatment for patients over the age of 55 with episodic or chronic migraine.**

✓ Although valproate is not recommended for those under the age of 55, for those who remain on it and who fulfil MHRA requirements, inform the patient of the risks to children exposed to valproate in utero and the need to use effective contraception while taking valproate and for 3 months after stopping (see Valproate Pregnancy Prevention Programme and CoSRH Guidelines and Statements | CoSRH).

✓ Male patients (of any age) on valproate should use effective contraception (condoms and female contraception) and continue to for 3 months after stopping valproate.

GABAPENTIN

R **Gabapentin should not be considered as a prophylactic treatment for patients with episodic or chronic migraine.**

MENSTRUAL MIGRAINE PROPHYLAXIS

R **Frovatriptan** (2.5 mg twice daily) **should be considered as a prophylactic treatment in women with perimenstrual migraine from two days before until three days after bleeding starts.**

R **Zolmitriptan** (2.5 mg three times daily) **or naratriptan** (2.5 mg twice daily) **can be considered as alternatives to frovatriptan as prophylactic treatment in women with perimenstrual migraine from two days before until three days after bleeding starts.**

✓ Women with menstrual-related migraine who are using triptans at other times of the month should be advised that additional perimenstrual prophylaxis increases the risk of developing medication overuse headache.

MEDICATION-OVERUSE HEADACHE

R **In patients overusing acute treatment, medication overuse should be addressed.**

R **The choice of strategy to address medication overuse should be tailored to the individual patient and may be influenced by comorbidities. Strategies include:**

- **abrupt withdrawal alone and preventative treatment may then be considered after a delay**
- **abrupt withdrawal and immediately starting preventative treatment**
- **starting a preventative treatment without withdrawal.**

✓ Consider withdrawing regular opioids gradually.

R **Prednisolone should not be used routinely in the management of patients with medication-overuse headache.**