Neurology – Headache as a new complaint – Adult Patient Assessment Pathway

May 2010

NHS SCOTLAND

Patient Presentation

Migraine

GP

General lifestyle advice:

- Regular meals (avoid snack foods and missing meals).
- Avoid excess alcohol, fizzy caffeinated drinks.
- Regular sleep and daily aerobic exercise (walking, cycling).
- Avoid specific triggers (glare, stress, foods, drinks, travel).
- Encourage use of Headache Diaries & Stress management.

For prophylactic medication options

NHSGG&C
NB: Topiramate no longer needs specialist supervision.

GP

Prophylaxis (trials suggest that prophylaxis provides a reduction in severity and frequency of headaches by 50%):

- Consider if 3 or more attacks per month or where attacks are very severe.
- Treat for at least 3 months.
- If anticonvulsant prophylaxis given to women of child–bearing age with caution; they should be counselled regarding side effects and associated risks in pregnancy*.
- Combination therapy may be required.

Medication Options:

- Beta–blockers: propranolol 80–240mg daily recommended as first line prophylaxis.
- Tricyclics: amitriptyline 10–150mg 2 hours before bedtime.
- Anti–epileptics (note above regarding caution in pregnancy): Sodium Valproate (800–1500mg/day) recommended for episodic migraine, Topiramate (50 mg–200mg/day) recommended for episodic and chronic migraine (BNF advises initiateTopiramate under specialist supervision).
- Other: Venlafaxine 75–150 mg daily is an alternative to tricyclic antidepressants.

Also consider:

- Stress management.
- Acupuncture.

Patient Support Groups

Migraine Action Association:
tel. 0116 275 8317
www.migraine.org.uk

Migraine Trust Helpline:
tel. 020 7462 6601
www.migrainetrust.org

NHS GG&C
Refer to Neurology when 4 preventative medications have been tried in turn, for 8 weeks each, in therapeutic doses, and there is no reduction in severity or frequency.

GP

Try three different strategies in succession.
Refer if unsatisfactory response.

Options for migraine of increasing severity

GP

Drug management for acute migraine:

N.B. The risks of medication overuse headache should be discussed with the patient and analgesic and triptan use limited to no more than 2 days a week on average.

1. Simple analgesics:

- Aspirin 900mgs (all severities).
- Ibuprofen 400mg (all severities/other NSAIDs).
- Paracetamol 1000mgs (mild/moderate severity).
- Aspirin plus metoclopramide.

2. Anti–emetics:

- Oral & rectal anti–emetics can be used to reduce symptoms of nausea and vomiting and to promote gastric emptying.

3. Triptans (recommended for all severities if previous attacks not controlled using simple analgesics):

- Almotriptan 12.5mg, eletriptan 40–80mg, rizatriptan 10mg and sumatriptan 100mg are the preferred oral triptans.
- If a patient does not respond to one triptan an alternative should be offered.
- Consider nasal or subcutaneous triptans if prominent nausea/vomiting.
- Triptans should be taken at/soon after, the onset of headache phase of the attack.
- A combination of triptan and NSAID may be helpful in prolonged attacks associated with recurrence.

4. Opiod analgesics should be AVOIDED in the treatment of acute migraine.

GP

Emergency treatment for severe migraine:

- Diclofenac (100mg) suppository or 75mgs IM, or
- Subcutaneous Sumatriptan 6mgs – (if no triptan already taken).
- Domperidone 30mg suppository.

N.B. OPIATES SHOULD BE AVOIDED

This information is available online at: http://www.18weeks.scot.nhs.uk/how-to-achieve-and-maintain-18-weeks/patient-pathways-1/