Migraine: Acute Therapy Guidelines (Adult)

NHS Oxfordshire Clinical Commissioning Group

General Advice

Patients should **try an acute intervention on at least three occasions** before deciding on therapeutic efficacy, because it is not unusual for efficacy to reveal itself only on the third attempt. **Aim for relief within 30-120 mins**.

Migraine stops gastric emptying (hence nausea). All acute therapy should be taken with a prokinetic where appropriate: **domperidone 10mg, or metoclopramide 10mg stat**, to aid absorption. **Use rapid release formulations** of acute therapies whenever possible. If presenting acutely with vomiting, any intramuscular anti-emetic may be helpful if available (e.g. **12.5mg Prochlorperazine IM stat**). Buccastem (prochlorperazine) also a reasonable choice.

Avoid paracetamol or NSAIDs on more than **15 days per month**, or triptans or codeine on more than **10 days per month**, otherwise there is a risk of **medication overuse headache** (normally manifests as a persistent grumbling headache between migraines). **COCP** is not allowed if; *1)* migraine with aura[1] within last 5 yrs (UKMEC 4), *2)* migraine with aura >5 years ago (UKMEC 3), or *3)* newly developing migraine without aura whilst on COCP (UKMEC3[C]). *See BNF and SPC for full guidance on all drugs below*.

Lifestyle Advice

- Regular light exercise
- Regular meal times
- Regular bed times
- Regular wake times
- Minimise stress
- Breakfast with fibre in the morning

1st Line: NSAIDS +/- Paracetamol 1g (Usual contraindications apply) Use soluble formulas where available.

- **Aspirin 900mg** stat. (max 4g in 24 hours)
- **Ibuprofen 600mg** stat (max 2.4g in 24 hours)
- **Naproxen 750mg** stat (max 1.25g in 24 hours)
- Consider **Diclofenac 100mg suppository** stat *if vomiting* (max 200mg in 24 hours).

1st or 2nd Line: Triptans

First Line:

- **Sumatriptan 50mg-100mg** stat (Max 100mg in single dose, 300mg per day).
  - *Avoid RADIS formulation (black-listed locally).*
- **Zolmitriptan 2.5mg** stat (Max 5mg in one day).

If vomiting is a problem: and anti-emetic with oral not helping:

- **Zolmitriptan 5mg nasal spray**, one spray stat into one nostril (max 10mg per 24 hours)
- *If necessary:* **Sumatriptan 6mg subcut** stat (max 12mg in 24 hours)

If pt gets unacceptable side-effects:

- **Almotriptan 12.5mg** stat (max 25mg in 24 hours).
- **Naratriptan 2.5mg** stat (max 5mg in 24 hours).
- **Eletriptan: 20mg – 80mg** stat (low dose = low SEs. But has a clear dose-response relationship).

For Recurrence ("re-bound" migraine):

- **Naproxen 500mg** stat at recurrence (rather than a second dose of triptan), or with initial triptan dose.
- The following are associated with less rebound: **naratriptan 2.5mg** stat, **eletriptan 40mg** stat, or **frovatriptan 2.5mg** stat.

3rd Line: A triptan combined with an NSAID.

General Advice

NSAIDs and anti-emetics can be taken during aura, in anticipation of headache onset. However, triptans will not work if taken during an aura – the patient should wait for headache onset and take **promptly**. If migraine returns, **take another triptan dose no sooner than 2 hours later**. *Triptan failure is not a class effect, so try other triptans.*
Common Side-effects: drowsiness, parasthesia (chest, face, limbs), blurred vision.
Contraindications: CVD, PVD, & uncontrolled HTN. Not licensed over 60 but may be offered if no risk factors.

Pregnancy: For detailed guidance on migraine in pregnancy and breastfeeding see related OCCG guidelines here.

1. Hemianopia, unilateral paraesthesia or weakness, dysphagia, visual scintillations, positive scotoma (bright shapes/blobs), or negative scotoma

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