PRIMARY CARE
WOMEN'S HEALTH FORUM

THIS RESOURCE IS INTENDED FOR UK HEALTHCARE PROFESSIONALS ONLY

10 TOP TIPS

for Managing Migraine Conditions

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This resource has been produced on behalf of the PCWHF. Remember that this is guidance and to please use your clinical judgement on a case-by-case basis.

Female patients are 3–4 times more likely to develop migraine. Around 1 in 4 patients aged 15–49 are living with migraine. Migraine significantly impacts quality of life, mood and relationships. It can also impact the ability to work, study and, in turn, has financial implications for some patients.

1.

Migraine without aura

Recurrent headache disorder manifesting in attacks lasting 4–72 hours.
Typical characteristics of the headache are unilateral location, pulsating quality, moderate or severe intensity, aggravation by routine physical activity and association with nausea and/or photophobia and phonophobia.

Diagnostic criteria:

A. At least five attacks[1] fulfilling criteria B–D below

B. Headache attacks lasting 4–72hr (untreated or unsuccessfully treated) [1]

C. Headache has at least two of the following four characteristics:

1. Unilateral location

2. Pulsating quality

3. Moderate or severe pain intensity

4. Aggravation by or causing avoidance of routine physical activity (e.g. walking or climbing stairs)

D. During headache at least one of the following:

1. Nausea and/or vomiting

2. Photophobia and phonophobia.

Migraine with aura

ID migraine questions to ask:

- Do you feel nauseated or sick to your stomach?
- Did your headache limit you from working, studying, or doing what you needed to do for any day in the previous 3 months?
- Does light bother you a lot more than when you don't have headaches?

Two or more positive responses suggests the patient suffers with migraine.

The positive predictive value is high at 0.93%. In other words, for 100 patients diagnosed as having migraine by the ID Migraine screener, 93 of these patients will have migraine. With 90% of patients, aura is unilateral, but seen with both, and should be there when eyes are closed, distinguishing it from slightly blurred vision that can occur in migraine but is not aura.[2]

2.

Menstrual-related migraine occurs between days -2 and +3 of the first day of menstruation (+1) in at least 2 out of 3 menstrual cycles; attacks happen at other times as well.

The cycles of rise and fall in oestrogen levels **typical of the female fertile period** are deemed responsible for an increased susceptibility to migraine in women.

'Pure' menstrual migraine (< 10%) occurs ONLY with menstruation and at no other time.

3.

Acute therapy options

- Non-specific treatment – NSAIDS +/- Anti emetics
- Specific treatments – Triptans, CGRP receptor antagonists

4.

Preventer therapy options

- Amitriptyline (if there are side effects with this, consider nortriptyline or dosulepin)
- Candesartan
- Propranolol
- Topiramate – be aware new MHRA guidance
- CGRP Receptor Antagonists
- Secondary care – Botox, CGRP inhibitors and modulators

5.

Lifestyle

- Recognition and avoidance of dietary and lifestyle triggers is essential
- Adequate fluid hydration, sleep hygiene and exercise are important
- Maintaining a healthy BMI and blood pressure is key

6.

Prodrome is usually the very first stage of a migraine attack. Symptoms such as yawning more than usual, food cravings, feeling down or irritable, feeling thirsty, neck stiffness and even an increased frequency of urine can be recognised.

These can be helpful warning signs, and it may be useful to recognise these, and treat migraine earlier to minimise full attack onset.

Keeping a migraine diary is hugely helpful in recognising prodrome, symptoms, frequency, and trigger.

7.

Red flags

Consider red flags in the history?

- Thunderclap headache
- Headache associated with a fever or rash
- Headache with changes in intensity, with different positions such as standing to lying, or increased pressure, such as coughing or straining.

8.

Migraine and contraception

- UK MEC guidance is very clear.
- Migraine with aura is a contraindication for the combined oral contraceptive (COC). Progesterone only is considered safe, consider LARC.
- For migraine without aura, we can consider COC.
- Tailored regimes can work well to reduce the frequency of migraine attacks.

Emergency contraception only contains progesterone, which means it can be taken by women who have either migraine without aura, or migraines with aura.

9.

HRT and migraine

- Perimenopause fluctuations in oestrogen is a common time for migraine frequency to increase.
- Transdermal HRT is safe to use in migraine with or without aura.
- Clonidine can be considered in appropriate patients for migraine and menopause.

10.

Migraine can be very debilitating, therefore **regularly reviewing the patients' symptoms**, and working through the therapy options to find the next best suitable alternative has very positive benefits to patient function.

References and Further Reading:

- [1] Migraine without aura – ICHD-3
- [2] Migraine with aura – ICHD-3