Migraine Q&A by GPs for GPs

Are there features I can look for which are reassuring when patients present with headache?

Over 97% of the headaches a GP will see are migraine or migrainous.

There is much talk of 'red flags' in headache and this can often unduly raise anxiety in patients and doctors in a primary care setting. Concerning features do occasionally exist. But look also to '**green flags**' – those features that, where present, can point you towards a primary headache disorder (most commonly migraine). Though anecdotal, most specialists see the following as reassuring: **episodic headaches** (asymptomatic in-between events), stereotypical headaches (the patient knows how they are going to 'pan out'), a **normal neurological exam and BP**, a **personal or family history** of migraine (it is a genetic disorder), and a past history of **travel sickness** (strongly co-morbid with migraine).

What else should help me understand what is going on?

Tension and migrainous headaches are triggered by change. This is usually a change in lifestyle, such as stress or disrupted sleep schedule. Physiological changes can also trigger headaches, the most common being hunger, dehydration, falling oestrogen levels (in women, such as in the run up to periods and around menopause) and inflammation (which is probably the cause of food triggers, or vaccines). Diagnosis is normally on history alone. More unusually, other physiological changes such as low iron, deteriorating renal function or deranged thyroid function can bring on headaches and prudent blood tests may be warranted if the history and examination leads you to suspect these.

Always check ESR +/- CRP in someone over the age of 50 so as not to miss giant cell arteritis (the most common secondary headache in a primary care setting). Rising blood pressure can bring on headaches too, so always check this. Try to correct whatever change you can with your patient. For example, if falling oestrogen is a trigger then blocking their cycles or offering parenteral HRT can help in perimenopause. HRT, however, is not a primary treatment for migraine and is only indicated if the patient has uncontrolled symptoms of menopause/perimenopause as well as migraine. If HRT is used to control vasomotor symptoms, aim to use topical treatment at the lowest required doses, and avoid cyclical HRT regimens which can exacerbate migraine.

Neck problems can contribute to worsening migraines. Do they need a chiropractic or physio assessment?

Does my patient need a brain scan?

Headache is usually a software problem, not a hardware problem. Structural brain pathology presenting as headache in isolation is unusual. In General Practice, the risk of finding serious secondary pathology on imaging in patients with isolated headache and a normal neurological examination is similar to that in people who do not have headache.

What pain relief should I recommend?

Many people find non-steroidal anti-inflammatory drugs (NSAIDs) more effective than paracetamol, but you may need higher doses in a rapidly absorbable formula – such as 600mg of ibuprofen lysine, 900mg dissolvable aspirin, or naproxen 500mg – 750mg stat.

These work better if taken *with* a triptan, such as sumatriptan (but there are 6 others to try if that is not tolerated or does not work – zolmitriptan, rizatriptan, almotriptan, naratriptan, frovatriptan and eletriptan.

Migraine stops the stomach emptying, and also reduces the absorption of the pain relief, so it is sensible to co-prescribe a pro-kinetic such as metoclopramide 10mg or domperidone 10mg to aid rapid absorption as well as treat any nausea. Anti-emetics are taken stat with the NSAID and triptan combination.

Go for big doses, taken as early as possible in a headache attack (e.g. within 30-45 minutes of an attack) – otherwise they don't work so well. Ideally patients who suffer migraine should not take pain relief (for any condition) on more than two days per week because three months of this can make

things worse – analgesic overuse headache. *Don't prescribe opioids* (unless the above is contraindicated) – they are the worst offenders of medication overuse headache. If 2 triptans are not effective to abort migraine, gepant medication can be tried. Sometimes this requires a referral to a headache specialist to initiate the medication.

When do I start a preventive medication and what am I aiming for?

Offer preventers when the patient is having too many headaches for them, but certainly if they are getting enough headaches to risk them developing analgesic overuse headache (see above). Preventers are not pain relievers so do not cause medication overuse headache.

What preventers can I offer?

Lots! You can choose one with reference to side-effect profiles, the patient's other co-morbidities, and their lifestyle. Some preventers are 'off label' use but frequently recommended by specialists and all the following are ok for initiation in General Practice: **amitriptyline** 10-50mg nocte, **propranolol** 80-240mg daily in divided doses (or once daily MR formula), **topiramate** 50-100mg BD or **candesartan** at or above 16mg once daily. If using topiramate ensure this is according to the MHRA pregnancy prevention programme. If 3 or more preventive medications are not effective consider referral to try newer migraine treatments including oral gepants, injectable CGRP monoclonal antibody therapies or Botox treatment.

Chronic Daily Headache - What's happening?

A migraine can last for days, or even weeks. We start to talk about chronic daily headache when they have had a headache unremitting for 8 weeks or more. The most common cause of this in headache clinics is analgesic overuse (25%). If a patient takes a paracetamol or NSAID on 15 or more days per month, or a triptan or codeine on 10 or more days per month, for three months or more, they may have more headaches and their migraines become more difficult to treat. Opioids should be avoided for this reason. The most effective treatment for many might be going 'cold turkey' off all painkillers for some weeks and treating the withdrawal symptoms. Opioids may require a gradual reduction.

While withdrawing from analgesics, consider co-starting a preventer. They don't work so well if analgesic overuse is a possibility, as headaches often worsen initially during the early weeks of analgesic washout, but start the preventer early as they can take 3 months to work.

It is often remarkable to see how well people respond to withdrawal of the overused analgesia and preventives are thought to work better after this point.

My patient is having a really tough time. What to do?

75% of patients suffer anxiety and/or depression in their lifetime – they probably share similar genetic aetiology. Treating one often helps the other, so take a holistic approach and attend to their co-morbidities.

Sign-post them to support from the Migraine Trust website

The Migraine Trust has fantastic information and resources (**migrainetrust.org)** offering support and information to patients and tips on how work or school may be able to make adaptations for them. They offer a helpline, email service and a Live Chat facility as well as online and in person support events.

The Migraine Trust is grateful to Dr Richard Wood (GP with a special interest in headache) and Ria Bhola (Headache Nurse Specialist) for their help in writing this leaflet.

the migraine trust

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