INFORMATION SHEETS FOR CLINICIANS

Headache Management System for Adults

Acute Treatments. Migraine

Strategies

When prescribing acute treatments there are two broad strategies

Stepped approach: start with simple analgesics and if ineffective step-up e.g. to a triptan

Stratified approach: target treatment based on attack severity

The stratified approach is associated with better health related outcomes

Adding an anti-emetic to an acute treatment improves efficacy unrelated to nausea and/or vomiting and can improve gastric motility and drug absorption.

How will a patient know if an acute treatment has helped?

The end point of an effective treatment is a significant response at two hours, because the natural history for most attacks is to spontaneously improve in 4 hours.

Which acute Treatment should I give?

Please consult the treatment algorithms in the guidelines/on the website for specific acute treatments

Choosing a Triptan

Sumatriptan 6 mg subcutaneous remains the most rapid and effective treatment for pain relief but has a higher risk of adverse events than other formulations.

Combination of a triptan and an NSAID with a long half-life, such as naproxen, is better than monotherapy.

In comparison to sumatriptan 100 mg:

Lower adverse events: naratriptan 2.5 mg, almotriptan 12.5 mg and frovatriptan 2.5 mg

Better 2-hour pain response: eletriptan 80 mg and rizatriptan 10 mg, almotriptan 12.5 mg

Lower recurrence rate: frovatriptan 2.5 mg, and eletriptan 40 mg

Contraindications to triptans include ischaemic heart disease, cerebrovascular disease, previous myocardial infarction, and uncontrolled or severe hypertension. The cardiovascular risk of triptans is low in the absence of these contra-indications

When to change to a new Triptan

If a treatment is not effective at 2 hours, then it is unlikely to work in that attack at that dose and considering an alternative acute treatment or combination treatment would be reasonable.

Lack of response to one triptan does not predict response to other triptans.

Triptans are most effective when taken early in the headache phase of the attack.

Triptans are less likely to be effective at treating the headache if taken during the preceding aura.

After 2 treatment failures with a particular triptan a trial with an alternative triptan is recommended. This rationale is based on the finding that in patients who experienced treatment failure in two attacks, 70% failed to respond in the third attack. Around 30% patients do not respond to any triptan.

Acute treatments can be associated with the development of medication overuse headache.

Opioids are not recommended for the treatment of acute headache because of the significant risk of medication overuse and the most protracted withdrawal.

For patients attending the emergency department parenteral NSAIDs or subcutaneous sumatriptan should be considered, and evidence also supports the use of antiemetics.

Opioids have not been shown to be significantly effective and should not be used.

Giving the patient written information

When prescribing a triptan it may be helpful to supplement the "in clinic" discussion with a patient information sheet - available on this site