6. Management of migraine

Migraine is typically a moderate-to-severe headache accompanied by nausea, vomiting and sensitivity to light and/or noise. It is commonly disabling. It is usually episodic, but there is an uncommon chronic form.

Principles of management

- Good treatment of migraine begins with education of patients, explaining their disorder and the purpose and means of management.
- Impact of migraine should be assessed prior to planning treatment:
  - the HALT-90 Index (Supplementary materials #18) assesses burden in terms of lost productive time.
- Triggers and predisposing factors should not be overemphasised but should nonetheless be considered early in management (with life-style modification when called for).
- Almost all patients with migraine will require drug therapy for acute attacks, but not necessarily prescription drugs (see Supplementary materials #7).
- Any patient who is not well controlled with acute therapy alone and whose quality of life is impaired by migraine, whether adult or child, should be offered prophylaxis in addition (see Supplementary materials #8).
- Every patient to whom treatment is offered, or whose treatment is changed, requires follow-up to ensure that optimum treatment has been established.

Education of patients

A patient information leaflet on migraine and its management, developed by Lifting The Burden, is available as Supplementary materials #21.

Key points of information are:

- migraine is a common disorder which, while it may be disabling, is benign;
- it is often familial, and probably genetically inherited;
- it cannot be cured but can be successfully treated;
trigger or predisposing factors are common in migraine, and should be identified and avoided or modified when possible, but not all can be;

- a headache calendar helps good management by recording over time:
  - the symptoms and pattern of attacks (eg, menstrual relationship);
  - medication use (thus identifying overuse);
- regular activity (eg, sport or exercise 2-3 times per week) may reduce intensity and frequency of migraine attacks.

**Hormonal contraception and HRT**

Many women report onset or aggravation of migraine after starting combined hormonal contraceptives (CHCs). Others, particularly those with menstrually-related migraine, report improvement, especially when CHCs are taken continuously without a week’s break.

The following advice on hormonal contraception may be given:

- migraine with aura and the ethinylestradiol component of CHCs are independent risk factors for stroke in women, especially in those under 50 years;
- alternatives to CHCs are therefore very strongly recommended for women with migraine with aura;
- a change from migraine without aura to migraine with aura after starting CHCs is a clear signal to stop immediately;
- progestogen-only contraception is acceptable with any type or subtype of migraine.

The following advice on hormone replacement therapy (HRT) may be given:

- HRT is not contraindicated in migraine with or without aura;
- decisions about commencing or continuing HRT should be made according to generally applicable criteria.

A patient information leaflet on female hormones and headache, developed by Lifting The Burden, is available as Supplementary materials #25.

**Follow-up**

- Use of a calendar is recommended to encourage adherence with prophylactic medication and record treatment effect. An example of a simple calendar is available as Supplementary materials #17.
- The use of outcome measures is recommended to guide follow-up. The following are included here among the management aids:
  - the HURT questionnaire (Supplementary materials #20) was developed expressly for primary care;
  - the HALT-30 Index (Supplementary materials #19) records lost productive time during the preceding month.
- Persistent management failure is an indication for specialist referral.