MIPCA
MIGRAINE IN PRIMARY CARE ADVISORS

Tailoring migraine management in primary care to the needs of the individual patient

Introduction

In the past, migraine has not always been managed well in primary care, where it is often under-estimated, under-diagnosed and under-treated.[1] However, the recent publication of new guidelines for migraine management has the potential to transform this situation. One of the key tenets of the new guidelines is the tailoring of care to the individual patient's clinical and personal needs.[2–4] This topic was addressed in a MIPCA advisory board held in Vienna on 25 October 2002, and a review article on the tailoring of migraine care is now in press.[5]

Migraine severity is assessed by measuring the impact on the patient's daily life, headache frequency and duration, and headache and non-headache symptom intensity, together with the patient's individual lifestyle needs and preferences. This information allows the physician to prescribe acute and, where necessary, prophylactic therapies appropriate to the patient's needs (Figure 1).

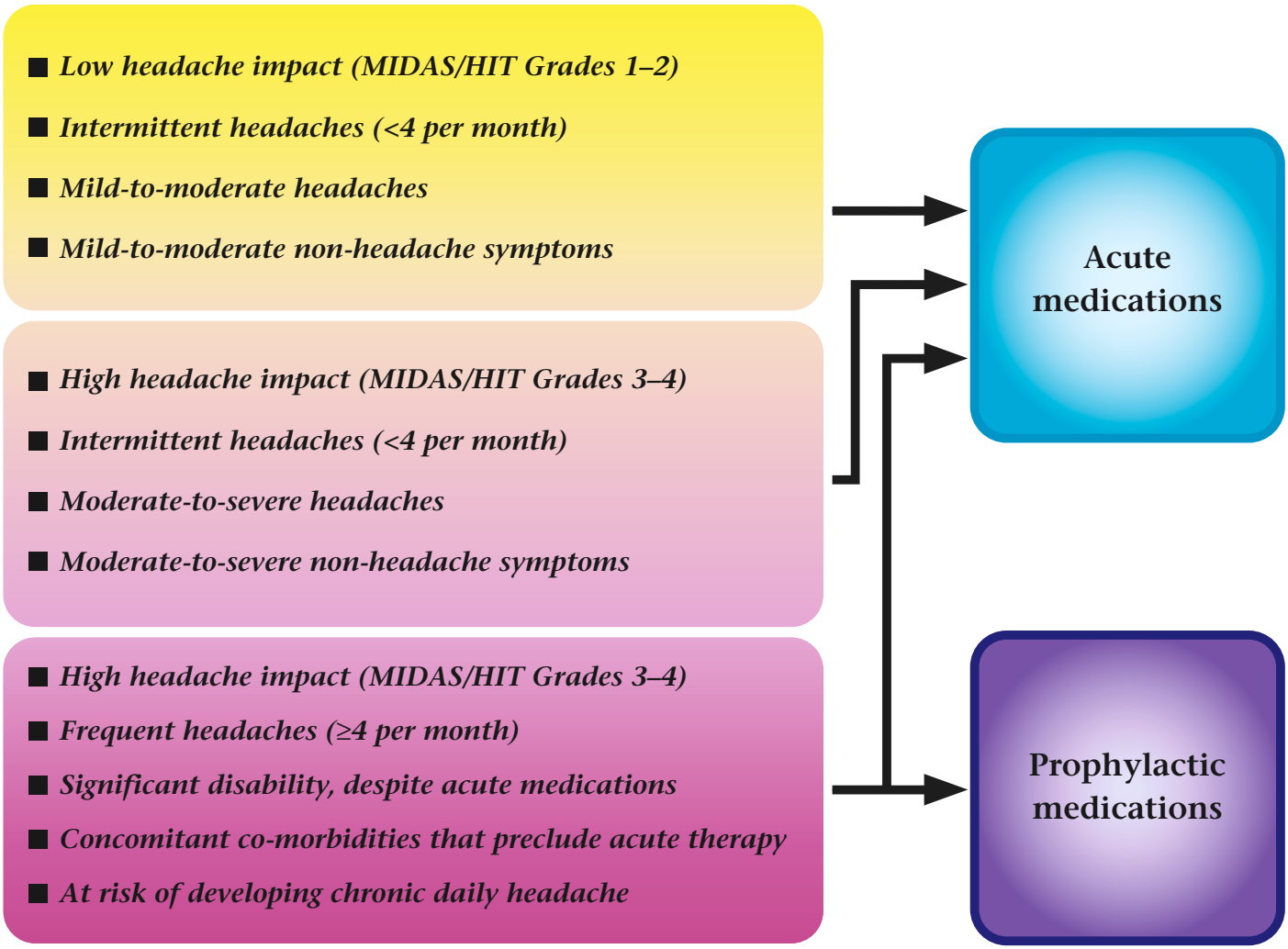

Figure 1. Criteria that the physician can use for treating migraine patients with acute medication only, or a combination of acute and prophylactic medication

Notes

- The Migraine Disability Assessment (MIDAS) Questionnaire and the Headache Impact Test (HIT) are tools for assessing headache severity/impact that have wide utility in clinical practice.[6]
- Chronic daily headache (CDH) is defined as a history of headaches each lasting >4 hours present on >15 days per month. CDH patients who use symptomatic headache medications on ≥2 days per week have medication overuse headache (MOH).

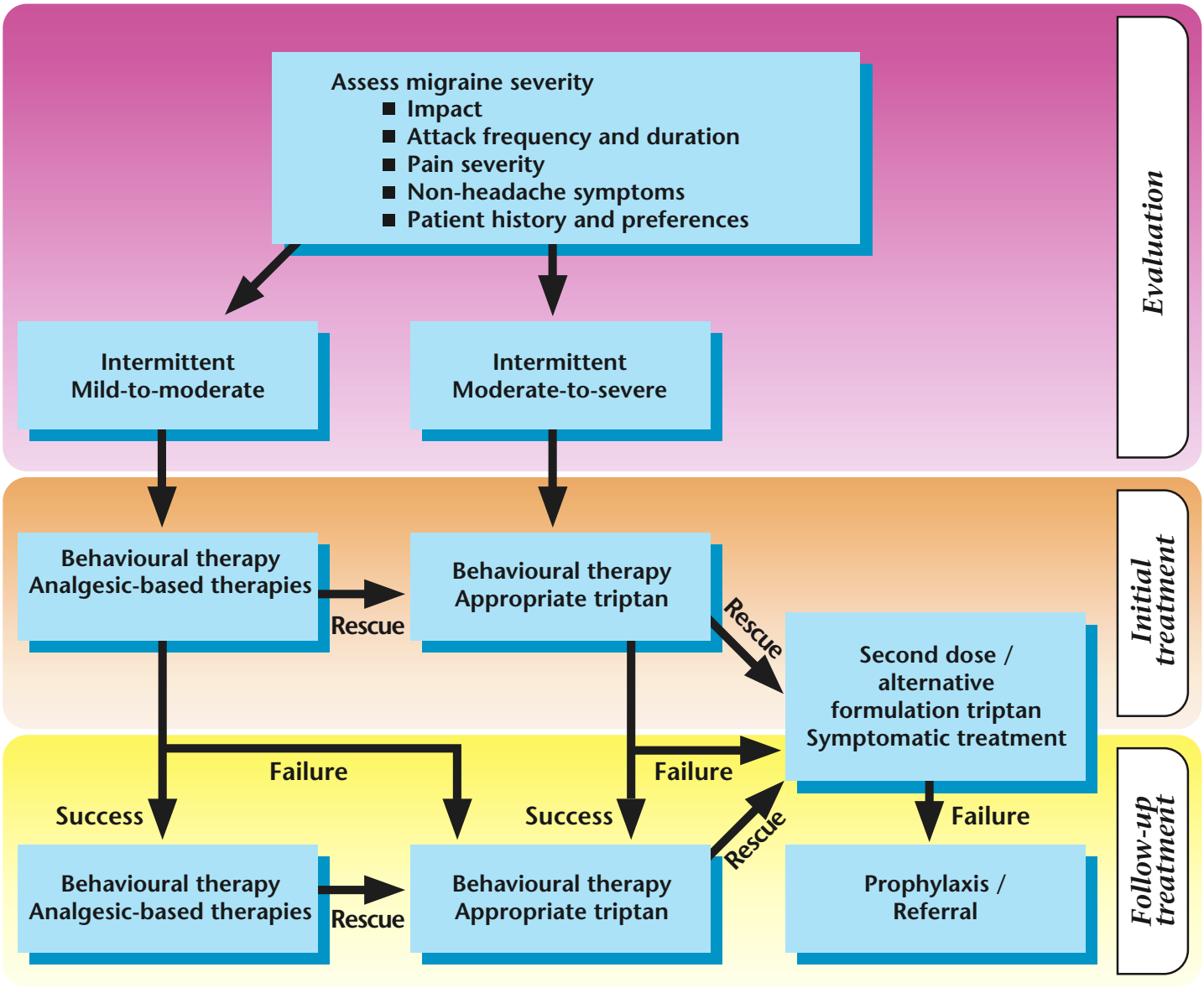

Figure 2. Strategies for tailoring acute medications to the individual patients' needs

Goals:

To rapidly relieve the headache and other migraine symptoms, and wherever possible, to permit the return to normal activities within 2 hours of treatment.

Recommendations:

- Provide acute medication to all migraine patients and recommend it is taken as early as possible in the attack.
- Provide rescue medication / symptomatic treatment for when the initial therapy fails (see Page 4).

Recommended therapies:

- Analgesic-based medications: aspirin; NSAIDs; aspirin plus metoclopramide; paracetamol plus domperidone.
- Migraine-specific therapies (triptans): sumatriptan; zolmitriptan; naratriptan; rizatriptan; almotriptan; eletriptan; frovatriptan.

Follow-up recommendations

- All patients should be followed up proactively, and acute and prophylactic medications closely monitored.
- Patients who are effectively treated should continue with their original medication.
- Patients who fail on their original therapy should be switched to other medications (see Page 4).

Prophylactic therapy

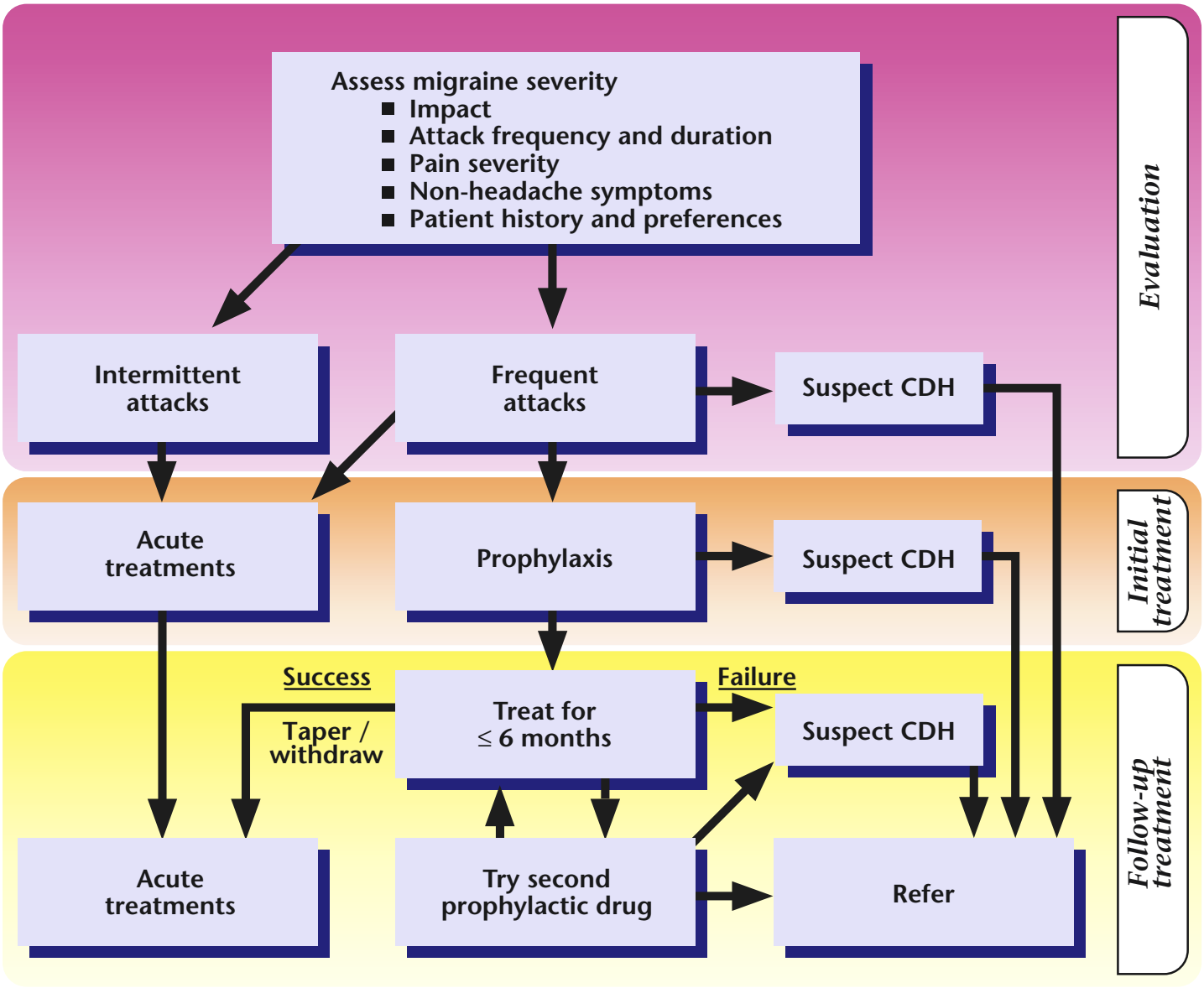

Figure 3. Strategies for tailoring prophylactic medications to the individual patients' needs

Goals:
To reduce the frequency of migraine attacks by >50%.

Recommendations:
- Prescribe prophylactic medications to patients who have four or more migraine attacks per month or who are resistant to acute medications.
- Recommend behavioural and/or physical therapy to all patients.
- Permit patients to use complementary therapies in addition to their prescribed medications.

Recommended therapies:
- Prophylactic therapies: beta-blockers (propranolol, metoprolol, timolol and nadolol); serotonin antagonists (pizotifen and methysergide); sodium valproate*; amitripyline*.
  - Start with a low dose and titrate up till an effective dose is reached.
- Behavioural/physical therapies: biofeedback; relaxation therapy; stress reduction; avoidance of triggers; cervical manipulation; massage; exercise.
- Complementary therapies: feverfew; magnesium; vitamin B2; butterbur acupuncture.

* Not currently licensed for migraine in the UK.

- Patients who fail on repeated acute and prophylactic medications should be referred to a specialist physician.
- Ensure that the patient is comfortable with the treatment recommended and that it is practical for their lifestyle and headache presentation.

Tailoring the medication to the patient

Acute medications

Patient feature	*Initial medication*	*Rescue medication*	*Switch at follow-up (if necessary)*
Mild-to-moderate attacks	Analgesic-based	2nd dose Oral triptan	Oral triptan
Analgesic-based therapies ineffective	Oral triptan	2nd dose Alternative oral triptan Nasal spray / subcutaneous triptan	Alternative oral triptan Nasal spray / subcutaneous triptan
Predictable moderate-to-severe attacks, with no significant GI symptoms	Oral triptan	2nd dose Alternative oral triptan Nasal spray / subcutaneous triptan	Alternative oral / ODT* triptan Nasal spray / subcutaneous triptan
Unpredictable attacks / lifestyles Preference for convenient formulation	ODT* triptan	2nd dose Nasal spray / subcutaneous triptan	Alternative oral / ODT* triptan Nasal spray / subcutaneous triptan
Fast onset attacks requiring a rapid onset of relief Severe, high-impact attacks Significant nausea Preference for a non-oral / non-injection formulation	Nasal spray triptan	2nd dose Subcutaneous triptan	Subcutaneous triptan Symptomatic treatment Prophylaxis
Fast onset attacks requiring a rapid onset of relief Severe, high-impact attacks Severe nausea or early vomiting Preference for an injection formulation	Subcutaneous triptan	2nd dose Symptomatic treatment	Prophylaxis Referral

* ODT = orally dispersible tablet

Prophylactic medications

- Medication should be provided for an adequate time period (minimum 3 months).
- If effective, prophylaxis can continue for 6 months, then tapered off.
  - The aim is total withdrawal and replacement with acute medication.
- If ineffective, another prophylactic medication may be tried.
- Always monitor for the possibility of CDH developing.

References

1 Lipton RB, Goadsby PJ, Sawyer JPC et al. Migraine: diagnosis and assessment of disability. Rev Contemp Pharmacother 2000;11:63–73.

2 Dowson AJ, Lipscombe S, Sender J et al. New guidelines for the management of migraine in primary care. Curr Med Res Opin 2002;18:414–39.

3 Matchar DB, Young WB, Rosenberg JH et al. Multispecialty consensus on diagnosis and treatment of headache: pharmacological management of acute attacks. Neurology 2000;54:www.aan.com/public/practiceguidelines/03.pdf

4 Bedell AW, Cady RK, Diamond ML et al. Patient-centered strategies for effective management of migraine. Primary Care Network, 2000.

5 Lipscombe S, Rees T, Dowson AJ. Tailoring migraine management in primary care to the needs of the individual patient. Family Practice 2003; in press.

6 Dowson AJ. Assessing the impact of migraine. Curr Med Res Opin 2001;17:298–309.

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About MIPCA

MIPCA is an independent charity (Number 1092433) working through research and education to set standards for the care of headache sufferers. MIPCA is a group of physicians, nurses, pharmacists and other healthcare professionals dedicated to the improvement of headache management in primary care. If you are interested in joining MIPCA, please complete the enclosed questionnaire and send it to MIPCA, Merrow Park Surgery, Kingfisher Drive, Merrow, Guildford GU4 7EP Tel/Fax 01483 450755.