

key points

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Migraine is a common neurovascular disorder

characterised by attacks of head pain that are typically unilateral and often described as severe and throbbing in association with nausea and sensitivity to sensory input, i.e. light, sound and head movement. Many patients resort to the overuse of painkillers, which leads to the development of a new type of headache or worsening of the pre-existing headache described as medication overuse headache.

It is associated with various combinations of nausea,

vomiting and sensitivity to light, sound or head movement. The headaches typically last 4-72 hours, up to 31% of migraineurs have aura on some occasions. Migraine is commonly episodic, with headaches occurring on < 15 days per month. Besides suffering from the typical migraine episodes patients frequently suffer from headaches that fulfil criteria for tension-type headache.

With an increasing intake of painkillers, patients often

complain of an escalation of migraine attacks or a transformation to a chronic daily background pain with exacerbations. Acute painkiller use, both prescription and OTC, should be enquired about in all cases and medication overuse headache suspected and managed if patients are taking any acute painkiller excessively.

Migraine is a neurovascular process, in which neural

events result in activation of blood vessels, which in turn leads to pain and further nerve activation. Migraine is not caused by a primary vascular event. There is no diagnostic test for migraine and therefore a good clinical history is vital.

Patients should be encouraged to have regular habits.

Regular sleep, exercise, meals, work habits and relaxation will be rewarded by a reduction in headache frequency. There is no evidence from controlled trials that specific diets ameliorate migraine.

NICE guidelines recommend adopting the stepped-down

approach to management. They suggest a combination of a triptan, NSAID or paracetamol, and an anti-emetic taken as early as possible during the headache. The decision to commence a preventative agent should depend on a combination of attack frequency, duration and severity, as well as response to abortive therapy and patient preference.

All oral preventative drugs should be started at a low

dose and increased slowly until therapeutic effects develop, side effects intervene or the ceiling dose of the agent is reached. The patient should be maintained on the optimum dose for an adequate period, generally three months. NICE recommends topiramate and propranolol as first-line agents. Although gabapentin is mentioned in NICE guidelines, there is now evidence that it is ineffective and so should not be used. Some patients may fail on a preventative treatment while overusing abortive medication but later find it effective when the overused drug is withdrawn.