

Prophylaxis treatment is used to reduce the number of migraine attacks in circumstances when acute therapy, used appropriately, fails to provide adequate symptom control (two or more attacks per month that produce disability lasting for 3 days or more). Always discuss the benefits and risks of prophylactic treatment for migraine with the patient, taking into account the person's preference, co-morbidities, risk of adverse events and the impact of the headache on their quality of life.

Effective prophylaxis has the potential to reduce the burden of disability caused by recurrent migraines. The British Association for the Study of Headaches (BASH) and NICE guidelines only recommend a few treatments (below) that have been proven to prevent recurrent migraines. Traditional options, such as pizotifen, have now been superseded.

1st Line PROPRANOLOL TABs - 80–240 mg daily in divided doses. Modified-Release preps are more costly, intermittently unavailable and without any additional clinical benefit

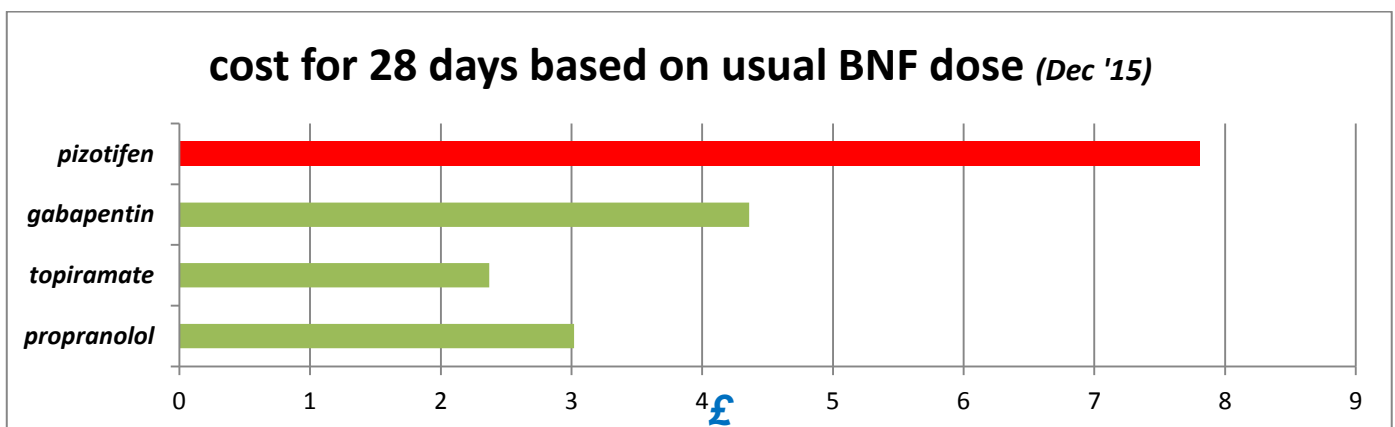
2nd Line TOPIRAMATE TABs - initially 25 mg at night for 1 week, then increased in steps of 25 mg at weekly intervals to usual dose 50–100 mg daily in 2 divided doses (max. 200 mg daily)

If both propranolol and topiramate are unsuitable or ineffective, then consider

3rd Line GABAPENTIN CAPs - initially 300 mg daily, increased according to response up to usual dose 1.2g daily in divided doses (max 2.4 g daily in divided doses)

For people who are already having treatment with another form of prophylaxis such as pizotifen or amitriptyline and whose migraines are well controlled, continue with the current treatment in the short-term;

- **Pizotifen (& clonidine):** have been widely used for many years but with little clinical trials evidence of efficacy. Both BASH & NICE found inadequate evidence for the effectiveness of pizotifen, which also commonly causes weight gain, in the prophylaxis of migraine. Pizotifen and clonidine have both been superseded with the 3 treatment options mentioned above.
- **Amitriptyline:** is widely used, off-label, to treat chronic painful disorders, including migraine. NICE states inadequate evidence was found for the effectiveness of amitriptyline in the prophylaxis of migraine. However, BASH states adequate efficacy for amitriptyline based on a single clinical study.



TIME TO REVIEW ?

BASH states that migraines should be considered as being cyclical and prophylaxis treatment is normally only required for short periods of exacerbation. Un-interrupted prophylaxis over long periods is rarely appropriate. This is further supported by NICE, which recommends patients need reviewing for continuing migraine prophylaxis 6 months after the start of prophylactic treatment. Gradual withdrawal should be considered for these patients and this is best achieved by tapering the dose over 2-4 weeks.

If prophylaxis is deemed to be necessary again following a successful period of abstinence, then regardless of which prophylaxis treatment the patient was originally prescribed, the evidence based treatment options should be used in preference to other agents.

REFERENCES:

- 1) BASH "Guidelines for All Healthcare Professionals in the Diagnosis and Management of Migraine" 2010
- 2) NICE CG150 "Headaches in over 12s: diagnosis and Management" Sept 2012, Updated Oct 2014
- 3) CKS "Migraines" accessed Nov 2015