Lancashire & South Cumbria Medicines Management Group

# Primary Care Adult Headache Management Pathway

Version 1.3 – November 2025

| VERSION CONTROL | | |
|---|---|---|
| **Version** | **Date** | **Amendments made** |
| Version 1.0 | October 2018 | Reformatted version 8 of the North West Headache Management Guideline for Adults to match other LMMG guidelines. Amended clinical content in line with NHSE OTC guidance. |
| Version 1.1 | April 2024 | Updated in conjunction with LTH neurology. MHRA alert for topiramate added. Valproate/valproic acid is not to be prescribed for migraine prophylaxis added at the request of LSCMMG. Reference to oxygen for cluster headache removed at the request of LSCMMG. |
| Version 1.2 | October 2024 | Atogepant added as per NICE TA 973 and amendments made to section on GCA. |
| Version 1.3 | November 2025 | Rimegpant and atogepant changed to Green (Restricted), pathway updated to reflect change. Rimegepant and atogepant factsheet added. |

Page

# Adult Headache Management Pathway

**Adult with a headache**

Additional information on headache types – page 2 and 3

**Emergency symptoms? See page 4** — Yes → **Refer to appropriate on-call hospital team**

No

**Giant cell arteritis, age >50yrs? See page 4** — Yes → Check ESR and CRP urgently. Start prednisolone 40mg daily. If red flags (jaw claudication or visual symptoms) 60mg daily → **Urgent referral to rheumatology. If visual symptoms same day referral to ophthalmology** ***Please consult local GCA Referral Pathway***

No

**2 week wait? See page 4** — Yes → 2WW referral (use neurology 2WW form)

No

**Red flags? See page 4** — Yes → **Refer to headache service OR specialist**

No

**Consider using a headache diary: is it a migraine or tension headache? See box 1 and page 5** — Yes → **First or infrequent migraines**

**Step 1:** simple analgesic +/- anti emetic – **avoid opioid analgesics**

**Step 2:** oral triptan +/- simple analgesic. An alternative triptan should be used if unsuccessful.

**See page 5 for details on prophylaxis**

No

**Is it 'cluster headache'? See page 5** — Yes → (same box as above)

No

**Other secondary causes?**
e.g. sinusitis, TMJ pain
Check: Hb, Calcium, TFT, ESR, CRP
Review lifestyle and medication

If unsuccessful → **Request advice from headache service (where commissioned) OR specialist**

**Rimegepant (acute or prophylaxis) or atogepant (prophylaxis only) can be considered on specialist advice – see page 5 and 7**

No

**Suspect:**
Medication overuse?
Drug induced? **See box 1 and page 5**

No → **Is it a migraine or tension headache? See box 1 and page 5**

Yes

**Stop suspected medication for 1 month – see page 5**

If unsuccessful → **Is it a migraine or tension headache? See box 1 and page 5**

No → **Refer to headache service OR specialist**

Yes → **Refer to headache service OR specialist**

**Box 1 – Migraine – see page 5 for prophylaxis**

- Throbbing pain lasting hours to 3 days
- Sensitivity to stimuli: light and sound, sometimes smells
- Nausea
- Aggravated by physical activity (prefers to lie or sit still)
- Aura, if present, evolves slowly (in contrast to TIA or stroke) and lasts minutes to hours.

**Chronic migraine (15 or more headache days per month, of which 8 or more are migraine)**

**Education and a better understanding of the condition can be facilitated by directing patients to:**

- www.nhs.uk/conditions/headaches/ OR
- www.migrainetrust.org

Explain the risk of medication overuse headaches to people using acute treatments (particularly any use of opiates and triptans >10 days a month)

If relevant, consider stopping combined oral contraceptives (note: combined oral contraceptives are contraindicated in migraine with aura)

**Lifestyle modification e.g. adequate hydration, sleep, exercise, STOP caffeine, avoid triggers and address psychosocial factors if necessary.**

Consider using a headache diary to record the frequency, duration and severity of headaches and to monitor the effectiveness of headache interventions. Can be used as a basis for discussion about headache disorder and impact: https://migrainetrust.org/wp-content/uploads/2021/06/The-Migraine-Trust-headache-diary-Word.docx

# Adult Headache Management Pathway – additional information

## Giant Cell Arteritis

- Incidence 2/10,000 per year
- Consider with presentations of new headache in people > 50 years old
- ESR can be normal in 10% - check CRP as well

**Symptoms may include:** jaw or tongue claudication, scalp tenderness, visual disturbance, temporal artery: prominent, tender, diminished pulse; other cranial nerve palsies, limb claudication

Many headaches respond to high-dose steroids. **However,** do not use the response as the sole diagnostic factor.

**Urgent Referral to:**
Rheumatology if GCA suspected
If visual symptoms same day referral to ophthalmology
*Please consult your local GCA referral pathway*

## 2 Week Wait – suspected cancer referral

**Headache with features of raised intracranial pressure:**

- Actively wakes a patient from sleep, but not migraine or cluster
- Precipitated by Valsalva manoeuvres e.g. cough, straining at stool
- Papilloedema

**Other symptoms of raised ICP headache include:**

- Headache is present upon waking and easing once up (analgesic overuse can cause this pattern) and worse when recumbent.
- Pulse synchronous tinnitus
- Episodes of transient visual loss when changing posture e.g. on standing
- Vomiting – significance should be judged in context as nausea and vomiting are features of migraine Headache with new-onset seizures
- Headache with persistent new or progressive neurological deficit

## Emergency symptoms or signs

Thunderclap onset
Accelerated or malignant hypertension
Papilloedema
Acute onset with focal neurological signs
Head trauma with raised ICP headache
Photophobia + nuchal rigidity + fever +/- rash
Reduced consciousness
Acute red eye ?acute angle closure glaucoma

**New onset headache in:**
3rd trimester pregnancy or early postpartum
Significant head injury – especially elderly patients with alcohol dependency or patients on anticoagulants

## Red flags

- Headache rapidly increasing in severity and frequency despite appropriate treatment
- Undifferentiated headache (not migraine or tension headache) of recent origin and present for > 8 weeks
- Recurrent headaches triggered by exertion
- New onset headache in : > 50 years old (consider giant cell arteritis; CNS malignancy); immunosuppressed or HIV or known malignancy

## Migraine prophylaxis

**Please note:** Sodium valproate and valproic acid should **NOT** be used for migraine prophylaxis

The decision to start prophylaxis should be based on the impact of the migraine on the patient's quality of life (e.g. >4 /month). The choice of treatment depends on patient preference, drug interactions and other co-morbidities. Treatment should be started at a low dose and gradually increased to the maximum effective and tolerated dose.

**Trial for 3 months titrating dose according to response before judging efficacy**

**First-line options – to be considered in primary care:**

Propranolol MR 80mg once daily, increased gradually to a maximum of 240mg once daily.

**NICE CG150** - People with depression and migraine could be at an increased risk of using propranolol for self-harm. Use caution when prescribing propranolol, in line with the Healthcare Safety Investigation Branch's report on the under-recognised risk of harm from propranolol.

Amitriptyline 10mg at night, increased in 10mg every fortnight as necessary to 100mg at night [unlicensed, but standard practice – see NICE CKS: Migraine]

Candesartan 2mg once daily, increased gradually to a **maximum** of 16mg daily.

Advise patients that riboflavin 400mg once daily may be effective in reducing migraine frequency and intensity for some people – purchase OTC (avoid if planning a pregnancy or pregnant).

**First-line options only in those not of childbearing potential – to be considered in primary care:**

Topiramate 25mg once daily, increased by 25mg every fortnight as necessary to 50mg twice daily.

**Topiramate - contraindicated for use in pregnancy and women of childbearing potential**

Topiramate can be considered first-line in primary care for the prevention of migraine for some patients. However, the MHRA have published guidance in June 2024. In summary:

- Topiramate is now **contraindicated for use in pregnancy and women of childbearing potential** unless specific conditions of a Pregnancy Prevention Programme are met.
- The use of topiramate during pregnancy has been linked to significant risks, including congenital malformations, low birth weight, and potential neurodevelopmental disorders such as intellectual disability, autism spectrum disorder, and ADHD.
- Healthcare professionals will receive materials, including guides, risk awareness forms, and patient cards, to support patient discussions and the implementation of the Pregnancy Prevention Programme. A healthcare professionals guide can be accessed via:

Topiramate (Topamax): introduction of new safety measures, including a Pregnancy Prevention Programme - GOV.UK (www.gov.uk)
https://www.medicines.org.uk/emc/rmm/3079/Document

**Second line options – on the recommendation of secondary care:**

Rimegepant 75mg **on alternate days**

Eligible for episodic migraine (**as per NICE TA 906**):
Between 4 and 15 migraine attacks per month, *and*
At least 3 preventative medications, at suitable dose/duration, have not worked, *and*
**Recommended by a specialist – LSCMMG RAG rating Green (Restricted)**

**Second line options – on the recommendation of secondary care continued:**

Atogepant 60mg ONCE a day

Eligible for preventing migraine (**as per NICE TA 973**):
At least 4 migraine days per month, *and*
At least 3 preventative medications, at suitable dose/duration, have not worked, *and*
**Recommended by a specialist – LSCMMG RAG rating Green (Restricted)**

**Please note:** if people with the condition and their healthcare professionals consider atogepant or rimegepant to be one of a range of suitable treatments, after discussing the advantages and disadvantages of all the options, use the least expensive. Take account of administration costs, dosage, price per dose and commercial arrangements.

**Additional prescribing information can be found on page 7**

## Cluster Headache

**More common in men**
**Severe pain lasting 30-120 minutes Unilateral, side locked**
**Agitation, pacing (note: migraine patients prefer to keep still)**
**Unilateral cranial autonomic features: tearing, red conjunctive, ptosis, miosis nasal stuffiness**

**Acute treatments:**
Offer a subcutaneous triptan (nasal triptan can be considered [unlicensed indication]).

**Do not offer paracetamol, NSAIDS, opioids, ergots or oral triptans**

## Tension-Type Headache

**Band like ache**
**Mostly featureless**
**Can have mild photo OR phonophobia but NO nausea**

**Treatment:**
Aspirin, paracetamol or an NSAID. Do **not** offer opioids

## Tension-type headache prophylaxis

Amitriptyline, following the same dose schedule as for migraine above.

Consider acupuncture, if available.

## Analgesic Overuse Headache

**Can be migrainous and/or tension-type**

At risk if analgesic intake ≥15 days per month (opiates ≥ 10 days) for ≥ 3 months OR triptan intake ≥ 10days per month for ≥ 3 months

**Treatment:** Stop analgesic or triptan for 3 months

# Rimegepant ▼ (Vydura®) and atogepant▼ (Aquipta®) – factsheet for primary care clinicians

Rimegepant and atogepant a new class of oral migraine medication. They block the CGRP receptor, which is involved with migraine generation. This is like the mechanism of action of the monoclonal antibody injection treatments already available through secondary care (erenumab, eptinezumab, fremanezumab, galcanezumab).

No special monitoring is required in terms of safety profile, but due to a theoretical risk we suggest monitoring blood pressure 6-monthly when used as a preventative.

Patients **must** keep a headache diary to record the number of migraine and headache days per month to allow review of response at 12 weeks.

**Prescribing criteria – rimegepant (used as acute treatment or preventative)**

**Acute**: Lack of efficacy/tolerability of simple analgesics **and 2** different triptans;
**or**
Triptans contraindicated and simple analgesics not effective.
RAG rated **Green** (no need for referral if acute treatment)

**Preventative**: **Episodic** migraine only (4 -14 headache days per month)
Adequate trials of at least **3 different classes** of migraine preventative have not worked (<50% reduction in migraine days per month)
Following recommendation from a specialist (via neurology advice & guidance) (RAG rated **Green (Restricted)**)
**Rimegepant must be assessed for efficacy, after 12 weeks of use.**

**Prescribing criteria – atogepant (preventative only)**

**Preventative**: **Episodic** migraine (4 -14 headache days per month); **or**
**Chronic** migraine (≥15 headaches per month, ≥8 are migraine)
Adequate trials of at least **3 different classes** of migraine preventative have not worked (<50% reduction in migraine days per month)
Following recommendation from a specialist (via neurology advice & guidance) (RAG rated **Green (Restricted)**)
**Atogepant must be assessed for efficacy, after 12 weeks of use.**

Atogepant is available at two strengths and price per pack is the same.

**Can rimegepant be used for prevention of chronic migraine?**
**No**, it is not licensed for use in chronic migraine

**Can atogepant be used to relieve a migraine attack?**
**No**, it is only licensed for prevention of migraine, both episodic and chronic

**Interactions**
Rimegepant doesn't interact with acute migraine treatments (triptans/analgesics) but does interact with cytochrome p450 3A4 inducers and inhibitors (e.g. erythromycin, diltiazem, itraconazole, verapamil, grapefruit) – see BNF/SPC for specific details also on renal and hepatic impairment.

**Interactions**
Atogepant interacts with strong cytochrome p450 3A4 inhibitors (e.g. itraconazole, erythromycin) and strong OATP inhibitors (e.g. rifampicin, ciclosporin, ritonavir)
Dose needs to be reduced if co-prescribed - see BNF/SPC for specific details, also on renal and hepatic impairment

**When to stop rimegepant?**

- **Acute**: If migraine has not responded to a trial of 2 doses for 2 separate attacks
- **Prevention**: After 12 weeks, if the frequency of migraine attacks does not reduce by at least 50%.
- Review the need for continued preventative use at 9 – 12 months

**When to stop atogepant?**

- After 12 weeks, if the frequency of migraine attacks does not reduce by at least 30% for chronic migraine or 50% for episodic migraine.
- Review the need for continued use at 9 – 12 months

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