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Rata Aotearoa

Mastering migraine management with acute and preventive strategies

Neurologist Rosamund Hill reviews the pharmacological management of migraine

Updated online health pathways for treatment of headache have recently been launched in parts of the country. Additionally, Migraine Foundation Aotearoa New Zealand is a recently established charitable trust with a comprehensive website providing valuable information for patients and health professionals (migrainefoundation.org.nz).

The aim of pharmacological management is to establish acute and preventive treatment that balances efficacy and tolerability using a collection of available drugs, many of which are not designed for migraine. Rizatriptan and sumatriptan, our only funded migraine-specific drugs, are the mainstay of acute treatment. New anti-migraine drugs targeting calcitonin gene-related peptide (CGRP) are available but not yet funded by Pharmac and provide highly effective, well-tolerated options for prevention.

Acute migraine attacks

The goal of acute treatment is to abort the attack – that is, to prevent it escalating and resolve the symptoms. This may require a single drug or a combination targeting both pain and nausea. Each patient will need to determine the best drug or combination for them, in consultation with their doctor.

Initial treatment with paracetamol plus aspirin or an NSAID (eg, ibuprofen, naproxen, diclofenac) is appropriate, adding a triptan if there is no improvement in 30 to 60 minutes. In some patients, a more effective approach is to use a triptan alone early, or a combination of a triptan plus paracetamol, NSAID and antiemetic. Caffeine can also help some people, either as a caffeinated drink or paracetamol plus caffeine tablets.[1]

Due to the risk of medication-overuse headache, an important consideration is the number of days per month the patient experiences headache. Triptans can only be taken up to 10 days per month on average, though they can be taken up to three times daily. Paracetamol, NSAIDs and aspirin can be taken up to 15 days per month on average, and on up to 10 of those days, triptans can also be taken.

If patients need acute medication this often, keeping a simple diary or record of days of medication use is helpful, and preventive medication should be introduced (see below).

It is important to treat even mild nausea or anorexia (loss of appetite) as poor gastric emptying will affect the absorption of oral analgesics. Some antiemetics also have anti-migraine benefit. Again, patients will need to try various antiemetics to determine which ones are helpful. Orodispersable ondansetron or buccal prochlorperazine may work more quickly. Metoclopramide and domperidone help gastric emptying.

It is important to try both available triptans – rizatriptan and sumatriptan – and to try sumatriptan at both 50mg and 100mg. Subcutaneous sumatriptan 6mg is usually more reliably effective; it works in 10 to 15 minutes and is useful in patients with nausea or vomiting. If patients don't like the taste of rizatriptan, they can swallow it as it is not absorbed in the mouth or oropharynx. If patients experience side effects with triptans but they are effective, it is worth trying 25mg of sumatriptan.

Patients need to be reassured that feeling hot or cold, tingling and chest tightness are expected side effects of triptans and not concerning. Chest pain, however, warrants investigation for underlying coronary artery disease.

If acute treatment is helpful but the migraine returns, the triptan can be repeated up to three times in the day. However, a patient not responding should not take another dose.

Opioids should be avoided in treatment of headache and migraine as they produce medication overuse in addition to dependence and pain sensitisation.

If acute treatment as discussed above is not effective or the migraines are frequent, preventive treatment needs to be considered.

Preventive medications

When to introduce a preventive drug depends on the frequency and severity of the migraines but also on the response to acute treatment. A patient with infrequent migraines that respond quickly and effectively to acute treatment may choose not to take daily prevention.

In addition to the established drugs, such as amitriptyline, nortriptyline, propranolol, topiramate and sodium valproate, two other preventive drugs to consider are candesartan and venlafaxine. Candesartan is very well tolerated and has minimal side effects, though it can lower blood pressure. It should be taken as a single dose at night, beginning with 4mg and increased no faster than 4mg per week up to 16–32mg at night. Venlafaxine can be started at 37.5mg once daily and increased no faster than 37.5mg per week up to 150mg daily.

> "Which preventive drug to choose depends on the patient's other health issues and potential side effects"

Which preventive drug to depends on the patient's other health issues and potential side effects

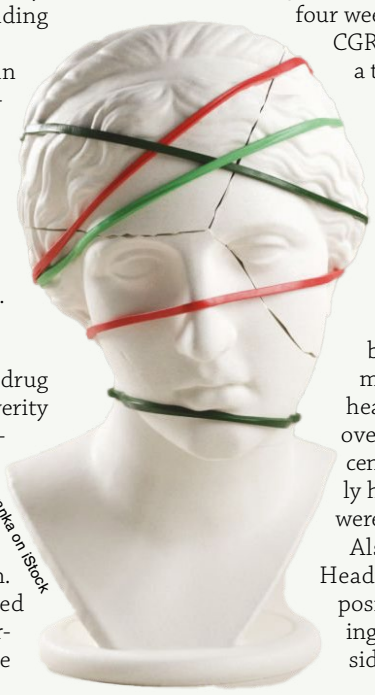
Which preventive drug to choose depends on the patient's other health issues and potential side effects. For example, in a patient with poor sleep, amitriptyline may be a good choice, whereas in a patient with anxiety and low body weight, topiramate might be avoided. In a patient with hypertension, a beta-blocker or candesartan might be chosen. Topiramate and sodium valproate should be considered carefully in women of childbearing potential due to the risk of neurodevelopmental abnormalities.

Preventive drugs should be started at a low dose and gradually titrated until there is benefit or the maximum recommended dose is reached, while monitoring the benefits and side effects.

Three new drugs available (but not yet funded) in New Zealand are specifically designed for migraine prevention and target the neuropeptide CGRP. Erenumab (Aimovig) and galcanezumab (Emgality) are monoclonal antibodies given as subcutaneous injections every four weeks. Atogepant (Aquipta) is a CGRP receptor antagonist taken as a tablet once daily.

All three drugs are well tolerated with minimal side effects. All are associated with constipation, and atogepant with mild weight loss. A 2024 prospective study of 5818 patients showed that over half of patients treated with CGRP monoclonal antibodies had a 50 per cent or more reduction in monthly headache days at six months, over one-quarter had a 75 per cent or more reduction in monthly headache days, and the drugs were well tolerated.[2]

Also in 2024, the American Headache Society published a position statement update, stating that these drugs can be considered as first-line options for



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migraine prevention.[3] They can be taken with the standard funded treatments, then the other treatment withdrawn if the new drug is effective and well tolerated.

Menstrually triggered migraines often occur in the week before the period or in the first few days of the period, and are often severe and poorly responsive to acute treatment. An effective approach may be to suppress ovulation.

This may be achieved using desogestrel (Cerazette) or a depot form of progesterone in women with migraine with aura, or using the combined oral contraceptive pill without a withdrawal bleed in women with migraine without aura.

A levonorgestrel intrauterine system (Mirena) may reduce the frequency of ovulation to some degree but does not consistently suppress ovulation. Goserelin with add-back oestrogen and progesterone can also be considered as it reliably suppresses ovulation.

Chronic migraine

Chronic migraine refers to 15 or more days per month of headache for at least three months, with eight of those days meeting the criteria for migraine. Very often, the migraines have progressed from intermittent to increasingly frequent and then to daily headache over a matter of months or years.

> "An important consideration is the number of days per month the patient experiences headache"

It is important to carefully assess the simple analgesic use, especially over-the-counter medications, to determine if medication overuse is contributing to, or causing, the increase in headaches. Brain imaging may be needed to look for secondary causes of chronic headache, such as idiopathic intracranial hypertension.

Preventive treatment should be introduced early before the headaches have reached 15 days per month. Other neuropathic pain treatments (eg, pregabalin or gabapentin) can be trialled.

Onabotulinumtoxin A is a proven treatment for chronic migraine and is effective in approximately 60–75 per cent of patients.[4] Usually, a trial of two treatments three months apart is performed, with careful diary recording of headache frequency and severity. It is approved by Pharmac for treatment of chronic migraine and available on a department-by-department basis around the country. ■

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Quiz answers

1. False **2.** True **3.** False

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How much do you already know?

Try this quiz

1. **There is no point in trying rizatriptan if sumatriptan does not work for acute treatment of migraine.**
   True/False
2. **New anti-migraine drugs targeting calcitonin gene-related peptide can be considered as first-line options for migraine prevention.**
   True/False
3. **Atogepant (Aquipta) is a monoclonal antibody given as a subcutaneous injection every four weeks.**
   True/False

Answers above

This publication has been reprinted with the support of AbbVie to provide an update on migraine management. The content is entirely independent and based on published studies and the author's opinion.

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(atogepant) tablets

MORE MIGRAINE FREE DAYS^[1-3]

AQUIPTA is indicated for prophylaxis of migraine in adults who have at least 4 migraine days per month[1]

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^Across 12 weeks, patients experienced more migraine-free days with AQUIPTA 60 mg vs. placebo.[1–3]
Episodic migraine (OTHE population analysis): Significant -4.1 (52.5%) mean migraine day reduction from 7.8 baseline (n=226) vs. -2.5 (33.3%) from 7.5 baseline for placebo (n=216; p<0.001).[1] **Chronic migraine** (OTHE population analysis): Significant -6.8 (35.4%) mean migraine day reduction from 19.2 baseline (n=257) vs. -5.1 (26.8%) from 19.0 for placebo (n=249; p<0.002).[1]

MINIMUM DATA SHEET AQUIPTA (atogepant) is an unfunded Prescription Medicine - charges will apply. Please review the full Data Sheet before prescribing. This is available from AbbVie Limited by calling 0800 900 030 or at abbv.ie/nz-aqui-ds.

INDICATIONS: AQUIPTA is indicated for prophylaxis of migraine in adults who have at least 4 migraine days per month. **CONTRAINDICATIONS:** History of hypersensitivity to atogepant or any components of AQUIPTA. Reactions have included anaphylaxis and dyspnoea. **PRECAUTIONS:** Hypersensitivity reactions, including anaphylaxis, dyspnoea, rash, pruritus, urticaria, and facial oedema have been reported with use of AQUIPTA. Some hypersensitivity reactions can occur days after administration. If hypersensitivity reaction occurs, discontinue AQUIPTA and institute appropriate therapy. Not recommended in patients with severe hepatic impairment; not recommended in pregnancy; lactation; sodium content; severe renal impairment or end-stage renal disease; safety and efficacy of AQUIPTA in paediatric population have not been established. See Data Sheet for details. **INTERACTIONS:** Potential for significant drug interactions requiring AQUIPTA dose adjustment when administered concomitantly with strong CYP3A4 inhibitors and inducers and strong OATP inhibitors, e.g., ketoconazole, itraconazole, clarithromycin, cyclosporine, rifampicin. See Data Sheet for details (not all AQUIPTA presentations may be marketed). **ADVERSE EFFECTS:** Nausea, constipation, fatigue/somnolence, decreased appetite, hypersensitivity (e.g., anaphylaxis, dyspnoea, rash, pruritus, urticaria, facial oedema). See Data Sheet for additional information on adverse effects. **DOSAGE AND ADMINISTRATION:** The recommended oral dosage of AQUIPTA is one atogepant 60 mg tablet once daily with or without food. See Data Sheet for additional information on dose modification. **Abbreviations:** CYP3A4, Cytochrome P450 3A4; OATP, organic anion transporting polypeptide; OTHE, off-treatment hypothetical estimand.

References: 1. AQUIPTA (atogepant) Data Sheet. **2.** Ailani J, *et al. N Engl J Med.* 2021;385(8):695-706. **3.** Pozo-Rosich P, *et al. Lancet.* 2023, 402:775-85.

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