

MIGRAINE HEADACHE

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MIGRAINE IS A NEUROBIOLOGIC DISORDER THAT OCCURS IN 18% OF WOMEN AND 6% OF MEN, BUT MAY BE UNDIAGNOSED OR UNDERTREATED

- Migraine is a genetically based disorder.
- It may be associated with altered sensitivity of the nervous system and activation of the trigeminal-vascular system.
- It is characterized by attacks of head pain and neurologic, gastrointestinal, and autonomic symptoms.
- It varies in frequency, duration, and disability among sufferers and between attacks.

General Principles of Headache Care

- Establish a diagnosis.
- Educate migraine sufferers about their condition.
- Discuss the rationale for each particular treatment, how to use it, and what adverse events are likely.
- Establish realistic patient expectations.
- Involve patients in managing their migraines. Encourage patients to use headache diaries to track triggers, frequency and severity of headaches, and response to treatment.
- Encourage the patient to identify and avoid triggers.
- Choose treatment on the basis of frequency and severity of attacks, the presence and degree of disability, and associated symptoms, such as nausea and vomiting.

- Create a formal management plan and individualize management. Consider the patient's preference and response to, and tolerance for, previously administered medications. Beware of increasing frequency of acute medication use. Identify coexisting conditions (such as heart disease, gastrointestinal disease, renal impairment, pregnancy, and uncontrolled hypertension), as they may limit treatment choices.

Diagnosis

- Migraine is a chronic condition with episodic manifestations; attacks vary in frequency and duration among sufferers and between attacks.
- The International Headache Society criteria are the basis for migraine diagnosis.
- If atypical features are present, exclude secondary headaches.
- There is insufficient evidence to recommend any diagnostic testing other than neuroimaging. Electroencephalography is not indicated in the routine evaluation of headache.
- Neuroimaging should be considered in non-acute headache patients with:
 - Unexplained abnormal neurological examination
 - Atypical headache, headache features, or an additional risk factor, such as immune deficiency

ACUTE CARE SHOULD BE INDIVIDUALIZED ON THE BASIS OF PATIENT'S SYMPTOMS AND LEVEL OF DISABILITY

Goals of Acute Treatment

- Treat attacks effectively, rapidly, and consistently to minimize adverse events.
- Restore the patient's ability to function.
- Minimize the need for backup and rescue medications.*
- Optimize self-care and reduce subsequent use of resources.

* A rescue medication is used at home when other treatments fail. It permits the patient to achieve relief without the discomfort and expense of a visit to the physician's office or emergency department.

Guide To Acute Treatment

- Act promptly. Failure to use an effective treatment promptly may increase pain, disability, and the impact of the headache.
- Use triptans (naratriptan, rizatriptan, sumatriptan, and zolmitriptan) and DHE in patients who have moderate or severe migraine, or whose mild-to-moderate headaches respond poorly to NSAIDs or combinations, such as aspirin plus acetaminophen plus caffeine, or other agents, such as ergotamine (see [table 1](#)).
- NSAIDs (oral), combination analgesics containing caffeine, and isometheptene combinations are options for mild-to-moderate migraine attacks or severe attacks that have been responsive in the past to similar agents.
- Select a non-oral route of administration for patients with migraine associated with severe nausea or vomiting.
- Do not restrict anti-emetics just to patients who are vomiting or likely to vomit.
- Use a self-administered rescue medication for patients whose severe migraine does not respond to (or fails) other treatments.
- Limit and carefully monitor opiate- and butalbital-containing analgesics.
- Guard against medication-overuse headache ("rebound headache"). Attempt to limit acute therapy to 2 days per week.

PREVENTIVE THERAPIES SHOULD BE USED WHEN MIGRAINE SUBSTANTIALLY IMPACTS A PATIENT'S LIFE

Consider preventive therapies when any of these are present:

- Frequent headaches (>2/week)
- Migraine significantly interferes with patient's daily routines, despite acute treatment
- Contraindication to, failure, adverse effects, or overuse of acute therapies
- Patient preference
- Presence of uncommon migraine conditions, including hemiplegic migraine, basilar migraine, migraine with prolonged aura, or migrainous infarction

Goals of preventive therapies

- Reduce attack frequency, severity, and duration
- Improve responsiveness to acute treatment
- Improve function and reduce disability

Guide to preventive medication use

- Use medication with best efficacy and fewest adverse events (see [table 2](#)).
- Take coexisting conditions into account.
- Select a drug that will treat more than one condition, if possible.
- Be sure that the coexisting disease is not a contraindication to the migraine treatment.

- Be sure that the treatments used for coexistent conditions do not exacerbate migraine.
- Beware of drug interactions.
- Start low and increase dose slowly until benefits are achieved or limited side effects occur.
- Give the drug an adequate trial at adequate dose (2 to 3 months).
- Avoid interfering medications (e.g., overuse of acute medications).
- Consider a long-acting formulation, which may improve compliance.
- Monitor the patient's headache diary.
- Re-evaluate therapy. If headache is controlled at 6 months, consider tapering or discontinuing treatment.

Non-pharmacologic therapies

- The following non-pharmacologic headache treatments may be used along or combined with preventive drug therapy to achieve additional clinical improvement:
 - Relaxation training
 - Thermal biofeedback with relaxation training
 - EMG biofeedback
 - Cognitive-behavioral therapy

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