MIGRAINE & HEADACHE

Treatment Recommendations & When to Refer

Most primary headaches share a similar pathophysiology, and thus treatment of migraines overlaps significantly with treatment of tension headache and other headache syndromes. There are rarer headache syndromes (eg. cluster headache, paroxysmal hemicrania/hemicrania continua, trigeminal neuralgia) for which treatment does differ somewhat; these will not be discussed here.

Common Headache/Migraine Symptoms:

- Unilateral or bilateral head pain
- Avoidance of physical activity
- Photophobia, phonophobia, nausea, visual or somatosensory auras (motor auras possible but less common).
- Pain may be throbbing, pressure-like, or sharp in nature.

Lifestyle Factors That Can Impact/Trigger Migraine:

- Poor sleep or untreated sleep apnea
- Overuse of caffeine
- Lack of exercise
- Alcohol
- Various dietary triggers

TREATMENT RECOMMENDATIONS:

1. Starting An Abortive Agent:

- Consider in any patient with episodic headache or prominent fluctuations in headache severity.
- Encourage to use immediately after headache onset (more effective).
- Can combine with OTC agents (NSAIDs, APAP) if needed. Avoid use of abortives >2 days per week to avoid rebound/medication overuse headache.
- Opioid (eg. norco) and barbiturate (eg. fioricet) containing medications are particularly likely to trigger rebound and should generally be avoided.

	Dosing	Side Effect	Comments
Sumatriptan	• tablet: 50-100mg • nasal spray: 10-20mg	Fatigue, flushing chest tightness	Typically first line; can choose nasal spray if need quicker onset
Rizatriptan	5-10mg		Reasonable 2nd option if sumatriptan not effective/not tolerated
Frovatriptan	2.5mg		Half-life 25hrs. Consider if HA is triptan responsive but recurs. Also good for menstrual migraine prophylaxis
Antidopaminergic nausea medications	• promethazine 12.5mg-25mg • prochlorperazine 5mg-10mg • metoclopramide 5-10mg	Cardiac arrythmia, acute dystonia. Prolonged frequent use can result in Parkinsonism and/or tardive disorders	Can be used in combination with triptans and/or OTC pain meds. Have anti-headache effect in addition to antiemetic effect

2. Intractable Migraine:

- Consider steroid burst over 6 days: 60mg -> 50mg -> 40mg -> 30mg -> 20mg ->10mg -> off. Could precede with 500-1000mg of IV solumedrol (or equivalent oral prednisone) x1

MIGRAINE & HEADACHE TIP SHEET *(CONTINUED)*

3. Starting and Selecting a Headache Preventative:

In general, a medication for headache prevention should be started for patients with a headache frequency of 2 days per week or greater and/or for patients with disabling headaches that are refractory to abortive therapy. Selection of a migraine preventative should be guided by consideration of patient comorbidities to avoid and/or exploit certain medication effects. Start at low dose and escalate slowly (typically no faster than every four weeks).

	Dosing	Side Effect	Comments
BP meds			
Propranolol	LA formulation: start 60mg, increase by 60mg as high as 240mg.	Hypotension, bradycardia, bronchoconstriction	Of BP class, typically considered first line
Verapamil	24hr ER formulation: start 120mg daily. Increase by 120mg as high as 240mg	Hypotension, bradycardia	
Candesartan	Start 8mg. Increase by 8mg as high as 32mg daily	Hypotension	2nd-3rd line; could consider other ARB if candesartan cost prohibitive
Antiseizure med			
Topiramate	25mg QHS. Increase by 25mg	Cognitive blunting, weight loss, paresthesias, nephrolithiasis, Pregnancy category D (cleft palate)	Consider in patients with seizures, tics, and/or weight loss goals.
Valproate	Start 250mg QHS. Increase by 250mg increments as high as 500mg BID	sedation, weight gain, hair loss, thrombocytopenia, hyperammonemia, transaminitis. Pregnancy category X.	Generally avoided given multiple side effects but could consider in patient with comorbid bipolar disorder or epilepsy
Antidepressants			
Venlafaxine	Start 37.5mg -75mg of ER formulation. Increase in 75mg Increments as high as 225 daily.	Insomnia, stomach upset	Consider in patients with mood disorders and/or chronic pain
Duloxetine	Start 30mg daily. Increase in 30mg increments as high as 120mg daily	Insomnia, stomach upset	
Nortriptyline/ Amitriptyline	Start 25mg QHS. Increase in 25mg increments as high as 100mg QHS	Sedation (amitriptyline>nortriptyline), dry mouth, weight gain, cardiac conduction abnormalities	Consider in patients with mood disorders, chronic pain, or insomnia
Nutraceuticals	• Riboflavin 400mg daily • Magnesium citrate 400mg daily to TID • Feverfew 50-300mg	Generally well tolerated. Magnesium can cause diarrhea. Feverfew can cause nausea, diarrhea, and/or mouth ulcers.	Consider in patients hesitant to start prescription med. These medications come in combination OTC pill called Migrelief

When to Refer:

A neurology referral is generally appropriate if two headache preventatives and an abortive therapy have failed to adequately control headaches. Other red flags that might signal the need for further evaluation include:

- Persistent visual changes
- Interictal neurological deficits
- New HA syndrome in patient > age 40 (check inflammatory markers for GCA in pts over 60)
- Discomfort localized to the face
- Unilateral headaches associated with autonomic features (rhinorrhea, lacrimation, ptosis, anisocoria) and/or psychomotor agitation