CLINICAL GUIDELINES

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Topic *(Examples: Diabetes, Asthma, COPD, Women's Health, etc.)*	Migraine: Acute Treatment
Guideline Source *(Examples: ADA, USPSTF, HTW, NHLBI, etc.)*	**Source:** Canadian Headache Society **Title:** "Acute Drug Therapy for Treatment of Migraine Headache" **Journal:** *Canadian Journal of Neurological Sciences* 2013 Sep;40(5 Suppl 3):S1-80
Guideline Link	http://headachenetwork.ca/wp-content/uploads/Acute-migraine-guideline.pdf
Guideline Original Date	2013
Guideline Most Recent Revision Date	No revision since 2013
Quality Measures *(for the year of QCEC review)*	N/A
HCC Documenting and Coding Tips *(for the year of QCEC review)*	N/A
Guideline Summary *(Summarize guideline and updated information)*	Created by the Canadian Headache Society **Objective:** To provide an overview of the objectives and target population of the guideline, and to review the general principles of acute pharmacological migraine therapy. The target population includes adults with episodic migraine (patients with migraine headache < 15 days/month). Specific medications are based on evidence for efficacy, tolerability, migraine attack severity, patient preference, and on the presence of co-existing disorders. **Background:** The International Headache Society (IHS) has classified two major subtypes: migraine without aura, and migraine with aura. Migraine without aura is the most common migraine subtype, and is characterized by headache attacks lasting 4 to 72 hours. Headache attacks are usually accompanied by other symptoms including photophobia, phonophobia, nausea, and sometimes vomiting. Individuals with migraine with aura experience in addition reversible focal neurological symptoms, which usually precede the headache and last up to 60 minutes, or occasionally longer. A strong recommendation means that the medication could be used for most patients, and that the benefits of therapy outweigh the potential risks (although contraindications still need to be observed). A weak recommendation indicates that the intervention could still be useful, but it would not be appropriate for many patients, often because of potential side effects. With a weak recommendation, the balance between risks and benefits is closer or more uncertain. **Recommendations:** 1. May be used for most patients with strong recommendation for use: a. High quality evidence i. Triptans (almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan) for moderate to severe severity ii. Aspirin (975-1000 mg) with oral metoclopramide (10 mg) if nauseated for all severities iii. Ibuprofen (400 mg) for all severities iv. Naproxen (500 or 550 up to 825 mg) for all severities v. Diclofenac potassium (50 mg) for all severities vi. Acetaminophen (1000 mg) alone or in combination with oral metoclopramide (10 mg) for mild to moderate severity vii. If migraine response to sumatriptan is inadequate, consider use of naproxen 500 mg simultaneously with triptan 2. May be used for some patients with weak recommendation for use: a. Moderate quality evidence:

i. Dihydroergotamine (intranasal or SC self-injection) for moderate to severe severity
ii. Ergotamine when triptans are not available
iii. Tramadol-APAP for moderate to severe severity when triptans and/or NSAIDs are ineffective or contraindicated (not for routine use)

b. Low quality evidence:
i. Codeine containing combination analgesics for moderate to severe severity when triptans and/or NSAIDs are ineffective or contraindicated (not for routein use)

3. Don't use routinely with strong recommendation against use:
a. Moderate quality evidence
i. Ergotamine should not be used routinely due to inferior efficacy compared to triptans and because of the potential for more side effects
b. Low quality evidence
i. Oral opioids including codeine due to lack of superiority to standard drugs (NSAIDs and triptans) and the risk of dependence/abuse, medication overuse headache, and the possibility of a withdrawal syndrome following discontinuation
ii. Tramadol alone or in combination with APAP due to lack of superiority to standard drugs and the risk of dependence/abuse, medication overuse headache, and the possibility of a withdrawal syndrome following discontinuation

4. Don't use with strong recommendation against use:
a. Low quality evidence
i. Butorphanol nasal spray due to lack of superiority to standard drugs and the risk of dependence/abuse, medication overuse headache, and the possibility of a withdrawal syndrome following discontinuation
ii. Barbiturate-containing combination analgesics due to lack of superiority to standard drugs and the risk of dependence/abuse, medication overuse headache, and the possibility of a withdrawal syndrome following discontinuation

5. Antiemetics in conjunction with other migraine medications with strong recommendation for use:
a. Moderate quality evidence
i. Metoclopramide (10 mg orally)