Complete Summary

GUIDELINE TITLE

Treatment of primary headache: acute migraine treatment. Standards of care for headache diagnosis and treatment.

BIBLIOGRAPHIC SOURCE(S)

Landy S, Smith T. Treatment of primary headache: acute migraine treatment. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache Foundation; 2004. p. 27-39. [11 references]

GUIDELINE STATUS

This is the current release of the guideline.

**** REGULATORY ALERT ****

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

On April 7, 2005, after concluding that the overall risk versus benefit profile is unfavorable, the U.S. Food and Drug Administration (FDA) requested that Pfizer, Inc voluntarily withdraw Bextra (valdecoxib) from the market. The FDA also asked manufacturers of all marketed prescription nonsteroidal anti-inflammatory drugs (NSAIDs), including Celebrex (celecoxib), a COX-2 selective NSAID, to revise the labeling (package insert) for their products to include a boxed warning and a Medication Guide. Finally, FDA asked manufacturers of non-prescription (over the counter [OTC]) NSAIDs to revise their labeling to include more specific information about the potential gastrointestinal (GI) and cardiovascular (CV) risks, and information to assist consumers in the safe use of the drug. See the FDA Web site for more information.

Subsequently, on June 15, 2005, the FDA requested that sponsors of all non-steroidal anti-inflammatory drugs (NSAID) make labeling changes to their products. FDA recommended proposed labeling for both the prescription and over-the-counter (OTC) NSAIDs and a medication guide for the entire class of prescription products. All sponsors of marketed prescription NSAIDs, including Celebrex (celecoxib), a COX-2 selective NSAID, have been asked to revise the labeling (package insert) for their products to include a boxed warning, highlighting the potential for increased risk of cardiovascular (CV) events and the well described, serious, potential life-threatening gastrointestinal (GI) bleeding associated with their use. FDA regulation 21CFR 208 requires a Medication Guide to be provided with each prescription that is dispensed for products that FDA

determines pose a serious and significant public health concern. See the FDA Web site for more information.

Additional Notice

On July 19, 2006, the FDA notified healthcare professionals and consumers of new safety information regarding taking medications used to treat migraine headaches (triptans) together with certain types of antidepressant and mood disorder medications, selective serotonin reuptake inhibitors (SSRIs) and selective serotonin/norepinephrine reuptake inhibitors (SNRIs). A life-threatening condition called serotonin syndrome may occur when triptans are used together with a SSRI or a SNRI. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Acute migraine

GUIDELINE CATEGORY

Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Neurology

INTENDED USERS

Health Care Providers
Physicians

GUIDELINE OBJECTIVE(S)

- To improve the medical treatment of headache
- To help physicians and other health care professionals to design a treatment plan, combining nonpharmacologic with pharmacologic approaches as necessary to:
    - Minimize symptomatology
    - Reduce disability
    - Improve quality of life

TARGET POPULATION

Patients with acute migraine

INTERVENTIONS AND PRACTICES CONSIDERED

Non-Pharmacological Therapy

1. Relaxation
2. Biofeedback
3. Visualization
4. Extracranial pressure
5. Cold compresses
6. Preventives:
    - Regular exercises
    - Maintaining regular sleep and meal schedules
    - Practicing overall good health strategies
    - Avoiding headache risk factors and triggers

Pharmacotherapy

1. Nonopioid analgesics
    - Acetaminophen
    - Caffeine
    - Aspirin + acetaminophen + caffeine
    - Isometheptene mucate + dichloralphenazone + acetaminophen
    - Nonsteroidal anti-inflammatory drugs (NSAIDs)
        - Acetylsalicylic acid
        - Celecoxib
        - Diclofenac
        - Flurbiprofen
        - Ibuprofen
        - Indomethacin
        - Ketoprofen
        - Ketorolac
        - Meclofenamate
        - Naproxen sodium

2. Opioid analgesics
    - Butorphanol
    - Codeine
    - Hydromorphone
    - Meperidine
    - Methadone

    - Morphine
    - Oxycodone
3. Ergotamines
    - Ergotamine tartrate
    - Dihydroergotamine (DHE)
    - Dihydroergotamine mesylate
4. Triptans
    - Almotriptan malate
    - Eletriptan
    - Frovatriptan
    - Naratriptan hydrochloride
    - Rizatriptan benzoate
    - Sumatriptan succinate
    - Zolmitriptan

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guidelines presented in this monograph represent the consensus of an advisory panel of practitioners chosen by the National Headache Foundation (NHF) for their expertise. In addition to incorporating the US Headache Consortium's recommendations, their conclusions reflect clinical experience and the most recent medical literature.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not applicable

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Acute Migraine Treatment

Despite recent advances in the science and treatment of migraine over the past decade, many clinicians have not significantly changed their approach to managing migraine. Nearly 60% of migraineurs continue to use over-the-counter (OTC) remedies exclusively to manage their headaches, despite a rise in the number of physician-diagnosed migraines. Many of these diagnosed patients still report significant suffering, highlighting the need for appropriate migraine treatment in the management of headache patients.

Effective migraine treatment begins with an accurate diagnosis and a thorough understanding of the impact a primary headache has on the patient's daily life. Clinicians should be aware of the use and the effectiveness of previous and current treatments, bearing in mind that both prescription and OTC products have the potential for exacerbating underlying headache patterns. Once a diagnosis is established, it is essential to take the time to explain the condition to patients.

Reassuring patients that their headaches are not caused by something life-threatening, such as a brain tumor or an aneurysm, is an important part of the treatment process. Just as important, patients need to know that you know their condition is real and that you are committed to working closely with them to develop a treatment strategy that will help them regain control of their lives. The following 5-step acute treatment strategy is recommended by the Primary Care Network and is endorsed by the National Headache Foundation:

1. Identify components of migraine symptomatology that allow for intervention as early as possible in the migraine process.
2. Select the best pharmacologic options for each patient.
3. Instruct patients in the proper use of their medications.
4. Encourage use of a headache diary to monitor treatment and medication usage.
5. Provide information resources for patient education.

Patient Involvement

Involving patients in the treatment decision process helps foster solid doctor-patient relationships, improves the chances for compliance, and leads to a more successful outcome. Be sure that patients fully understand and agree with the goals of treatment (see table below). Thoroughly explain the purpose of each part of the treatment plan, the need for follow-up care, and the pros and cons of all available medications. Set realistic expectations—let patients know that although there is no "cure," appropriate treatment can relieve symptoms and improve quality of life.

US Headache Consortium Goals for Acute Migraine Treatment
• Treat attacks rapidly and consistently and prevent recurrence • Restore the patient's ability to function • Minimize the use of backup and rescue medications • Optimize self-care and reduce subsequent use of resources • Be cost-effective in overall management • Have minimal or no adverse events

Early Intervention

Understanding the evolution of the migraine process and the therapeutic phases (see figure 3.1 of the original guideline document) enhances migraine symptom recognition and promotes optimal acute treatment strategies. A migraine headache often begins with mild to moderate pain, similar to the pain of a tension-type headache. As the attack progresses, the features of the headache become more migraine-like. Early intervention--at the onset of the attack--increases the likelihood of successful treatment, including a pain-free response, a reduction in the number of headache recurrences, and improved tolerability of headaches when they do occur.

Stratified Treatment

Individualized acute migraine treatment is based on many factors, including pain intensity, degree of disability, comorbidity, presence of nausea and vomiting, previous treatment(s), and patient preferences. This individualized, or tailored, treatment approach is recommended not just for individual patients, but should also address individual attacks in a single patient. A stratified treatment approach matches treatment to pain intensity and/or disability level. For example, patients with mild to moderate attacks may benefit from the use of nonsteroidal anti-inflammatory drugs (NSAIDs) or combination analgesics, such as aspirin plus acetaminophen plus caffeine, or acetaminophen plus isometheptene plus dichloralphenazone. For patients with more severe pain or disability, use of migraine-specific medication (triptans, ergotamines) is recommended. In general, triptans are better tolerated, easier to administer, and more efficacious than ergotamines. Use of a non-oral triptan or dihydroergotamine (DHE) with or without an antiemetic for migraines presenting early with nausea or vomiting, for rapid escalation of pain (time to peak intensity within 1 hour), and for intractable migraine can be beneficial.

Formulation, dose, and route of administration are also important considerations. Non-oral routes with the addition of an antiemetic are effective if the headaches are accompanied by nausea and/or vomiting. In general, injections are faster and more effective than suppositories and nasal spray. Tablets, although slower-acting and less effective, may be the patient's preferred drug delivery method, especially when the optimal dose is prescribed. Often, to achieve optimal control of a patient's headache pattern providers must prescribe more than one formulation of abortive, or acute, medication.

If the initial treatment fails, a backup medication should be discussed and provided to the patient. For example, if analgesics are used without success, a triptan or an ergotamine could be considered. Similarly, if a triptan or an ergotamine fails, patients may benefit from the use of neuroleptics, parenteral ketorolac, or combination analgesics that contain opioids.

Medication Overuse

A caveat about acute migraine treatment is to avoid headache due to medication overuse or rebound headache. Keep in mind that medication overuse can occur with almost all analgesics, opioids, ergotamines, caffeine, or triptans. Some patients with frequent disabling headaches may overuse their medication, leading to chronic daily headache along with growing dependence on and habituation to the medication. Withdrawal symptoms, including increased headache, are characteristic upon discontinuation of acute medication. In addition, when patients are trapped in a medication-overuse headache pattern, they are refractory to preventive medications. In most cases, headache improvement will occur after an analgesic washout period.

Medication overuse can be avoided by prescribing appropriate doses and limiting acute pharmacologic therapy to less than 2 to 3 days a week on a regular basis. Physicians should warn their patients that medication overuse can lead to chronic daily headache and a host of serious medical conditions, such as gastrointestinal bleeding, liver dysfunction, and kidney disease. Keeping diaries of headache symptoms and medication use may be valuable in preventing this problem.

Rescue Treatment

Rescue treatment connotes an ineffective outcome from abortive treatment and a need for effective symptom relief, with the goal of averting an unscheduled visit to a physician office or hospital emergency department. A treatment plan including a rescue strategy should be discussed and implemented during a routine office visit. Multiple therapeutic agents can be considered in this role, such as judicious use of opioids or corticosteroids. In addition, future attacks might benefit from the addition of combinations of NSAIDs or antidopaminergic drugs or in-office treatment with intravenous (IV) divalproex sodium. If rescue therapy is required on a regular basis--more than twice a month--attempts should be made to find a more effective first-line abortive agent and the patient should be evaluated for prophylactic treatment. Again, patient diaries may be helpful for guidance in tailoring treatment.

Nonpharmacologic Treatment

Nonpharmacologic approaches, which can also be beneficial for acute migraine treatment, are covered extensively elsewhere in *Standards of Care* (e.g., "Behavioral Interventions for Management of Primary Head Pain" and "Alternative Headache Treatments"). Headache risk factors and triggers, sleep disruption, delaying meals, stress, and occasionally specific foods or beverages or odors should be identified and avoided whenever possible. Nonpharmacologic treatments are often adjunctive to acute treatment, although at times and especially early in the evolution of a migraine they may be effective and may eliminate the need for pharmacologic interventions. Nonpharmacologic treatments commonly employed are relaxation, biofeedback, visualization, extracranial pressure, and cold compresses. Regular exercise, maintaining regular sleep and meal schedules, and practicing overall good health strategies are also an important part of the treatment regimen but are more effective as preventives than as treatments.

Pharmacologic Treatment

Medications used routinely for acute migraine therapy include nonopioid and opioid analgesics, ergotamines, triptans, and combination therapy, or copharmacy. The US Headache Consortium guidelines for acute management of migraine are listed in the tables below. Agents should be chosen on the basis of documented efficacy, patient preferences, side effects, and the presence or absence of coexisting conditions. (See Tables 3.2 and 3.3 in the original guideline document for specific dosages, routes, and clarifications.)

Table: Nonopioid Medications

MEDICATION	US HEADACHE CONSORTIUM GUIDELINES
COMBINATIONS	
Aspirin 250 mg + acetaminophen 250 mg + caffeine 65 mg	***Group 1***: Reasonable first-line treatment choice for mild to moderate migraine attacks or severe attacks that have been responsive in the past
Isometheptene mucate 65 mg + dichloralphenazone 100 mg +	***Group 2***: May be a reasonable choice for patients with mild to moderate headache

MEDICATION	US HEADACHE CONSORTIUM GUIDELINES
acetaminophen 325 mg	
NSAIDs[a]	
Acetylsalicylic acid	Group 1
Celecoxib	No controlled trials
Diclofenac	Group 2
Flurbiprofen	Group 2
Ibuprofen	Group 1
Indomethacin	No controlled trials
Ketoprofen	No controlled trials
Ketorolac	Group 2
Meclofenamate	No controlled trials
Naproxen sodium	Group 1

[a] NSAIDs can be combined with migraine-specific therapies

Table: Migraine-Specific Therapy (Triptans and Ergotamines)

MEDICATION	US HEADACHE CONSORTIUM GUIDELINES
Triptans[b]	
Almotriptan malate 6.25 mg and 12.5 mg (p.o.)	***Group 1***: Reasonable first-line treatment choice for moderate to severe migraine attacks
Eletriptan 20 mg and 40 mg	Group 1[a]
Frovatriptan 2.5 mg	Group 1[a]
Naratriptan hydrochloride 1 mg and 2.5 mg (p.o.)	Group 1
Rizatriptan benzoate 5 mg and 10 mg (p.o.) or MLT (orally disintegrating tablet)	Group 1
Sumatriptan succinate 6 mg subcutaneous (SQ) injection	Group 1
Sumatriptan intranasal 5 mg and 20 mg	Group 1
Sumatriptan succinate 25 mg, 50 mg, and 100 mg (rapid-release, p.o.)	Group 1
Zolmitriptan 2.5 mg and 5 mg (p.o) or ZMT (orally disintegrating tablet) 5 mg Nasal Spray	Group 1
Ergotamines[c]	
Ergotamine tartrate 2 mg sublingual	Group 3: Inconsistent evidence
Ergotamine tartrate 1 mg and caffeine 100 mg (p.o.)	Group 3
Ergotamine tartrate 2 mg and caffeine 100 mg (per rectum)	Group 3
Dihydroergotamine 1.0 mg	Group 1
Dihydroergotamine mesylate (intranasal)	Group 1

Notes to table:

Group 1: Substantial empirical evidence and pronounced clinical benefit
Group 2: Moderate empirical evidence and clinical benefit
Group 3: Conflicting or inconsistent evidence
Group 4: Empirical evidence indicating clinically ineffective

[a] Using the criteria applied by the US Headache Consortium, the guideline developers anticipated that this grouping would have been assigned had the data been available at the time of the original Guidelines publication.

[b] Triptans are contraindicated in the presence of uncontrolled hypertension, history of myocardial infarction (MI), ischemic or structural heart disease, cerebrovascular disease, peripheral vascular disease, and basilar or hemiplegic migraine. Triptans should not be used within 24 hours of treatment with ergot-type drugs and other triptan drugs.

[c] Ergotamines are contraindicated in presence of uncontrolled hypertension, history of myocardial infarction, ischemic or structural heart disease, cerebrovascular disease, peripheral vascular disease, hepatic or renal dysfunction, sepsis, pregnancy, or basilar or hemiplegic migraine. Ergotamines should not be used within 24 hours of triptans and other ergot-type drugs.

Precautions/Contraindications: NSAIDS: ulcer disease, significant hepatic or renal disease.

Precautions/Contraindications: Acetaminophen: hepatic disease.

Precautions/Contraindications: Aspirin: chicken pox, influenza in children or adolescents.

Precautions: Over-the-counter remedies (OTC) for headaches have long been a staple of headache patients in the United States and other countries. Although many headache patients obtain benefit from these agents, the patients may not inform their physicians that they are using them. Because these agents are available without a prescription, patients presume they are without risk of adverse effects or interaction with other medications or have no effect on their headache management program. Eliciting information on their use and providing patient education related to these agents and their proper use in a treatment program are fundamental to good headache practice.

Nonopioid Analgesics

Many patients with mild to moderate headaches will often respond favorably to simple analgesics, such as aspirin or acetaminophen. Sometimes simple analgesics are combined, and analgesics may be formulated with caffeine or other adjuvants. These combinations may offer several advantages, such as enhanced analgesia, reduced side effects because of lower drug doses, and convenience. Some physicians, however, believe that these agents are more likely to lead to overuse and dependence, so their use should be monitored carefully. Still, in most instances, individuals with mild to moderate headaches do not seek medical care for their headaches.

NSAIDs are among the most commonly prescribed medications in the world and should be considered a first-line option for migraine treatment. However, their effectiveness is often limited by their gastric toxicity. Newer-generation NSAIDs, known as cyclooxygenase-2 (COX-2) inhibitors, may offer increased efficacy with a lower risk of gastrointestinal side effects. Adequate doses are necessary to ensure effectiveness. If one NSAID does not provide relief, consider a trial with another before moving on to a different class of drug. Isometheptene-containing compounds are superior to placebo and because of their relative safety should be considered an appropriate choice for patients with mild to moderate headache.

Opioid Analgesics

Opioid is an inclusive term that refers to all agonists and antagonists with morphine-like activity. Despite considerable controversy surrounding their use, opioids are an effective and commonly prescribed migraine treatment. Partial agonists, such as butorphanol, may have a lower potential for tolerance and dependence, but abuse of these agents still commonly occurs. To minimize the risks of rebound, abuse, and dependence, opioids should be reserved for patients with moderate to severe pain that does not respond to nonopioid agents. Opioids are also appropriate for acute treatment of migraine headaches in patients who cannot tolerate, or have contraindications to, other migraine drugs or who are pregnant.

Oral opioid combinations (e.g., codeine plus aspirin or acetaminophen) may be considered when sedation side effects will not put the patient at risk and the risk for potential abuse has been addressed. Parenteral opioids may be considered for rescue therapy, under supervision, again when sedation side effects will not put the patient at risk and the risk for potential abuse has been addressed.

Opioids should be administered by the most appropriate route for the clinical circumstance, and dosages should be adjusted to account for differences in bioavailability between the oral, parenteral, and rectal routes of administration. Suggested doses are listed in table 3.4 of the original guideline document. General guidelines for opioid usage limit use to no more than 3 days per week, with monthly limits established below maximum-use parameters.

Ergot Derivatives

Ergotamine is an appropriate choice for patients who have moderate to severe migraine that does not respond to analgesics or who experience significant side effects from other migraine medications. Ergotamine tartrate is available as a sublingual preparation, as well as an oral tablet and a suppository when combined with caffeine, which may enhance absorption. Most ergotamine combinations have lower rates of nausea and vomiting than ergotamine alone. DHE is a weaker arterial vasoconstrictor but almost as potent a venoconstrictor as ergotamine. Like the triptans, DHE is active at the 5-HT1B/1D receptors, but unlike the triptans, DHE also has activity at a variety of other serotonin, adrenergic, and dopaminergic receptors, which may account for its pharmacologic activity. In addition to its use as a nasal spray and an injectable medication for acute migraine headache, repetitive DHE IV has become the mainstay of acute treatment for intractable headache.

Triptans

Collectively, selective 5-HT1B/1D agonists are known as the "triptans." Sumatriptan, the first triptan to be developed and tested, is the most extensively studied drug in the history of pharmacologic migraine treatment. It has been shown to be effective in relieving headache pain, as well as nausea, photophobia, and phonophobia, and in restoring patients' ability to function. Triptans should be considered first-line treatment for most migraine attacks, other than for those that respond to analgesics or combination agents. None of the triptans should be considered for patients with a history of significant ischemic heart disease, Prinzmetal's angina, uncontrolled hypertension, or strictly basilar or hemiplegic

migraine. Worldwide experience suggests, however, that the risk of a serious cardiac-related adverse event attributable to triptans is quite low.

The triptans are all available as traditional oral tablets. In addition, 2 of these agents, rizatriptan and zolmitriptan, are found in tablets that dissolve readily in the mouth, which allows the drug to be taken without fluids. Sumatriptan tablets are now available in a rapid-release formulation that is designed to disintegrate quickly. Sumatriptan and zolmitriptan are also available as nasal spray formulations. The use of a nasal spray may prove beneficial in those patients who have early onset of nausea or vomiting with their headaches or where a rapid onset of activity is needed. The gold standard of triptan therapy remains the subcutaneously administered formulation of sumatriptan.

Rational Copharmacy

Rational polypharmacy should be considered in refractory or dissatisfied patients. Rational polypharmacy includes combining a nonopioid analgesic with a triptan or an ergotamine, combining an antiemetic with a nonopioid analgesic or a triptan or an ergotamine, or combining an antiemetic, a nonopioid analgesic, and a triptan or an ergotamine. The combination of metoclopramide with an NSAID or aspirin has been used extensively in Europe and in clinical trials in the United States. Many consider the combination of an NSAID with a triptan to improve pain reduction and decrease recurrence rates. The combination of triptans with ergotamines or other triptans is contraindicated.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

In addition to incorporating the US Headache Consortium's recommendations, the conclusions reflect clinical experience and the most recent medical literature.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Involving patients in the treatment decision process helps foster solid doctor-patient relationships, improves the chances for compliance, and leads to a more successful outcome.

POTENTIAL HARMS

- A caveat about acute migraine treatment is to avoid headache due to medication overuse or rebound headache. Some patients with frequent

disabling headaches may overuse their medication, leading to chronic daily headache along with growing dependence on and habituation to the medication. Withdrawal symptoms, including increased headache, are characteristic upon discontinuation of acute medication. In addition, when patients are trapped in a medication-overuse headache pattern, they are refractory to preventive medications. Physicians should warn their patients that medication overuse can lead to chronic daily headache and a host of serious medical conditions, such as gastrointestinal bleeding, liver dysfunction, and kidney disease.

- Nonsteroidal anti-inflammatory drugs (NSAIDs) are among the most commonly prescribed medications in the world and should be considered a first-line option for migraine treatment. However, their effectiveness is often limited by their gastric toxicity.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Triptans are contraindicated in presence of uncontrolled hypertension, history of myocardial infarction (MI), ischemic or structural heart disease, cerebrovascular disease, peripheral vascular disease, and basilar or hemiplegic migraine. Triptans should not be used within 24 hours of treatment with ergot-type drugs and other triptan drugs.
- Ergotamines are contraindicated in presence of uncontrolled hypertension, history of myocardial infarction, ischemic or structural heart disease, cerebrovascular disease, peripheral vascular disease, hepatic or renal dysfunction, sepsis, pregnancy, or basilar or hemiplegic migraine. Ergotamines should not be used within 24 hours of triptans and other ergot-type drugs.
- Precautions/Contraindications: Nonsteroidal anti-inflammatory drugs (NSAIDS): ulcer disease, significant hepatic or renal disease
- Precautions/Contraindications: Acetaminophen: hepatic disease
- Precautions/Contraindications: Aspirin: chicken pox, influenza in children or adolescents
- The combination of triptans with ergotamines or other triptans is contraindicated.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Drug therapy is constantly evolving as new research, clinical trials, case reports, and opinions are published. Many of the drugs recommended in these guidelines are not approved by the US Food and Drug Administration (FDA) for treatment of headache, nor are they necessarily the same as those therapies recommended by the manufacturer for labeled indications. Their use in headache, however, may be supported by the scientific literature and by the authors' clinical experiences. While efforts have been made to ensure accuracy, the authors and publisher do not assume responsibility for the consistent updating of available information for these guidelines, nor for any errors or omissions, nor for any consequences thereof. The onus is on the practitioner to evaluate recommendations in light of

the clinical condition of the patient and recent medical literature. The authors advise the practitioner to consult other sources, especially the manufacturers' warnings and precautions, before prescribing any drug with which they are unfamiliar. Practitioners are also advised that while these guidelines will address the needs of many patients, there will be circumstances calling for exceptions to these recommendations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Foreign Language Translations
Patient Resources
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Landy S, Smith T. Treatment of primary headache: acute migraine treatment. In: Standards of care for headache diagnosis and treatment. Chicago (IL): National Headache Foundation; 2004. p. 27-39. [11 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004

GUIDELINE DEVELOPER(S)

National Headache Foundation - Private Nonprofit Organization

SOURCE(S) OF FUNDING

National Headache Foundation

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Authors: Stephen Landy, MD, and Tim Smith, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available from the National Headache Foundation, 820 N. Orleans, Suite 218, Chicago, IL 60610; Phone: (888) NHF-5552; Web address: www.headaches.org

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- The complete headache chart. Chicago (IL): National Headache Foundation (NHF); 2 p. Electronic copies available in Portable Document Format (PDF) from the National Headache Foundation Web site
- National Headache Foundation fact sheet. Chicago (IL): National Headache Foundation (NHF); 2004 Oct. 2 p. Electronic copies available in Portable Document Format (PDF) from the National Headache Foundation Web site.

Print copies: Available from the National Headache Foundation, 820 N. Orleans, Suite 218, Chicago, IL 60610; Phone: (888) NHF-5552; Web address: www.headaches.org

PATIENT RESOURCES

The National Headache Foundation (NHF) has created a variety of educational resources for patients, including informative brochures, a patient diary for migraines, Power Point presentations, and patient guides; many of these resources are available in both Spanish and English. Some of these items are available as print copies for purchase through the NHF online store. Electronic versions of other resources are available through the consumer education section of the NHF Web site.

Print copies: Available from the National Headache Foundation, 820 N. Orleans, Suite 218, Chicago, IL 60610; Phone: (888) NHF-5552; Web address: www.headaches.org.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on April 8, 2005. The information was verified by the guideline developer on April 26, 2005. This summary was updated by ECRI on June 16, 2005, following the U.S. Food and Drug Administration advisory on COX-2 selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on August 29, 2006, following the U.S. Food and Drug Administration advisory on Triptans, SSRIs, and SNRIs.

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