



Quick Reference: MEDICATIONS RECOMMENDED FOR HEADACHE MANAGEMENT IN ADULTS

Refer to full guideline for migraine treatment in pregnancy and lactation

Table 1: Migraine

Acute Migraine Medication					
1 st line	ibuprofen 400 mg, ASA 1,000 mg, naproxen sodium 550 mg, acetaminophen 1,000 mg, diclofenac 50 mg				
2 nd line	Triptans: oral sumatriptan 100 mg, rizatriptan 10 mg, almotriptan 12.5 mg, zolmitriptan 2.5 mg eletriptan 40 mg, frovatriptan 2.5 mg, naratriptan 2.5 mg <ul style="list-style-type: none">Subcutaneous sumatriptan 6 mg if vomiting early in the attack. Consider for attacks resistant to oral triptans.Oral wafer: rizatriptan 10 mg, zolmitriptan 2.5 mg, if fluid ingestion worsens nauseaNasal spray: zolmitriptan 5 mg, sumatriptan 20 mg, if nausea Antiemetics: domperidone 10 mg, metoclopramide 10 mg, for nausea				
3 rd line	550 mg naproxen sodium in combination with triptan				
4 th line	Fixed-dose combination analgesics (with codeine if necessary - not recommended for routine use)				
Prophylactic Migraine Medication		Starting Dose	*Titration: Daily Dose Increase	Target Dose / Therapeutic Range	Notes
1 st line	propranolol	20 mg bid	40 mg/week	40-120 mg bid	Avoid in asthma
	metoprolol	50 mg bid	50 mg/week	50-100 mg bid	
	nadolol	20-40 mg once daily	20 mg/week	80-160 mg daily	
	amitriptyline	10 mg hs	10 mg/week	10-100 mg hs	Consider if depression, anxiety, insomnia or tension-type headache
	nortriptyline	10 mg hs	10 mg week	10-100 mg hs	
2 nd line	topiramate	25 mg once daily	25 mg/week	50 mg bid	Consider 1 st line if overweight
	candesartan	8 mg once daily	8 mg/week	16 mg once daily	Few side effects; avoid in pregnancy or when pregnancy is planned
	lisinopril	10 mg once daily	10 mg/week	20 mg once daily	More side effects than candesartan; avoid in pregnancy or when pregnancy is planned
Other	divalproex sodium	250 mg once daily	250 mg/week	750-1,500 mg daily, divided bid	Avoid in pregnancy or when pregnancy is planned
	pizotifen	0.5 mg daily	0.5 mg/week	1-2 mg bid	Monitor for somnolence and weight gain
	OnabotulinumtoxinA	155-195 units	No titration needed	155-195 units every 3 months	For chronic migraine only – headache on ≥15 days per month
	flunarizine	5-10 mg hs		10 mg hs	Avoid in depression
	venlafaxine	37.5 mg once daily	37.5 mg/week	150 mg once daily	Consider in migraine with depression and/or anxiety
Over the Counter	magnesium citrate	300 mg bid	No titration needed	300 mg bid	Efficacy may be limited; few side effects
	riboflavin	400 mg daily		400 mg daily	
	co-enzyme Q10	100 mg tid		100 mg tid	
*Titration: Dosage may be increased every two weeks to avoid side effects					
<ul style="list-style-type: none">For most drugs, slowly increase to target doseTherapeutic trial requires several monthsExpected outcome is reduction, not elimination of attacksIf target dose not tolerated, try lower doseIf med effective and tolerated, continue for at least six monthsIf several preventive drugs fail, consider specialist referral					

Table 2: Tension-Type Headache

Acute Medication	
<ul style="list-style-type: none"> ibuprofen 400 mg ASA 1,000 mg naproxen sodium 550 mg acetaminophen 1,000 mg 	
Prophylactic Medication	
1 st line	amitriptyline 10-100 mg hs OR nortriptyline 10-100 mg hs
2 nd line	mirtazapine 30 mg hs OR venlafaxine 150 mg once daily

Table 3: Cluster Headache (consider early specialist referral)

Acute Medication	
<ul style="list-style-type: none"> subcutaneous sumatriptan 6 mg intranasal zolmitriptan 5 mg or sumatriptan 20 mg OR 100% oxygen at 12 litres/minute for 15 minutes through non-rebreathing mask	
*Prophylactic Medication	
1 st line	verapamil 240-480 mg per day (higher doses may be required)
2 nd line	lithium 900-1,200 mg per day
Other	topiramate 100-200 mg per day OR melatonin up to 10 mg hs
*Note: If more than two attacks per day, consider transitional therapy while verapamil is built up (e.g., prednisone 60 mg for five days, then reduced by 10 mg every two days until discontinued, or occipital nerve blockage with steroids by trained physicians).	

Abbreviations: hs – at bedtime; bid – twice a day; tid – three times a day

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KEY MESSAGES*

DIAGNOSIS AND IMAGING

- Rule out secondary headache when making a diagnosis of a primary headache disorder.
- Neuroimaging is not indicated in patients with recurrent headache with the clinical features of migraine, a normal neurological examination, and no red flags.
- Neuroimaging, sinus X-rays, cervical spine X-rays, and EEG are not recommended for the routine assessment of the patient with headache. History and physical/neurological examination is usually sufficient to make a diagnosis of migraine or tension-type headache.

DIFFERENTIAL DIAGNOSIS

- Migraine is by far the most common headache type in patients seeking help for headache from physicians.
- Migraine is historically under-diagnosed and under-treated. Many patients with migraine are not diagnosed with migraine when they consult a physician.
- Migraine should be considered in patients with recurrent moderate or severe headaches and a normal neurological examination.
- Patients consulting for bilateral headaches which interfere with their activities are likely to have migraine rather than tension-type headache and may require migraine specific medication.
- Consider a diagnosis of migraine in patients with a previous diagnosis of recurring “sinus” headache.
- Monitor for medication overuse.
- Medication overuse is considered present when patients with migraine or tension-type headache use combination analgesics, opioids, or triptans on 10 or more days per month or acetaminophen or NSAIDs on 15 or more days a month.

MANAGING MIGRAINE

- Comprehensive migraine therapy includes management of lifestyle factors and triggers, acute and prophylactic medications, and migraine self-management strategies.
- ASA, acetaminophen, NSAIDs, and triptans are the primary medications for acute migraine treatment.
- A triptan should be used when NSAIDs are not effective.
- Opioid-containing analgesics are not recommended for routine use for migraine.
- Butalbital-containing combination analgesics should be avoided.
- Vast amounts of over-the-counter analgesics are taken for headache disorders and treatment is often sub-optimal.
- A substantial number of people who might benefit from prophylactic therapy do not receive it.

*Refer to *Guideline for Primary Care Management of Headache in Adults 2nd edition*, for management details: www.topalbertadoctors.org/cpgs/10065