




















MIGRAINE:

AGENTS FOR ACUTE TREATMENT

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Sept 13

	Generic/ TRADE	PREGNANCY CATEGORY	INDICATIONS and CONTRAINDICATIONS (CI)	SIDE EFFECTS (SEs)	DRUG (DI) INTERACTIONS	COMMENTS	DOSING  usual; MAX/24hr	\$ per 6 doses
TRIPTRANS (5HT _{1B/D} Agonists)	Naratriptan AMERGE, g  (1,2.5mg D shaped tab); OTC in UK		1st line for mod & severe attacks • ≤40% of all attacks & 25% of all patients do not respond ¹ ; high recurrence rate (~40% @24 _{hr} IMITREX) CI •cardiac  or cerebrovascular disease (or high risk for the same); risk of MI ~1/5,000,000 migraine attacks treated ^{2,49} •hypertension uncontrolled; PVD; ?diabetes •hemiplegic or basilar migraine Caution: decrease dose/avoid •↑CV risk: e.g. ♂>40yrs; ♀>50yrs; smoker •Renal dysfunction with nara/suma •Hepatic dysfn with all triptans •Sulfa allergy?: Almo/Elet/Nara/Suma •Aspartame ZOMIG Rapimelt, MAXALT wafer → caution in PKU pts EDS Criteria: Treat migraine headache (Age >18yr)	For all: (13 trials suggest no differences) ⁶⁵  Chest discomfort or tightness <7% (or tightness of neck/throat); (Actual CV events extremely rare if low CV risk); nausea, facial flushing, tingling & paresthesia; CNS: dizziness<10%, fatigue, somnolence; poor taste ^{Suma} ; Suma SC burning @ site Differences generally not clinically significant; trends: •Almo/Nara/Frova→less SEs ^{slow onset} •Riza⇒more recurrence? •Zolmi⇒more adverse effects? •Suma = 50mg dose often as effective as 100mg & as well tolerated as 25mg • baseline cardiac evaluation/ECG recommended for ♂>40yr & ♀>50yr	• Serotonin syndrome (e.g. agitation, excitement, hypomania, myoclonus, tremor, hyperreflexia, ataxia, motor weakness, fever/chills, diarrhea) with concurrent MAOIs, SSRIs, TCAs or lithium. MAOIs = stop at least 2 weeks prior to triptans (except Nara, Almo & Frova); caution with others • Do NOT use within 24hr of DHE , other ergot preps or other triptans (risk of additive vasoconstriction/ coronary vasospasm) •↑level of Zolmi ^{use ≤ 5mg/24h} with cimetidine, propranolol, ciprofloxacin & fluvoxamine	•Selective 5HT-1 receptor agonists ^{2hr response: NNT= 2-4} • Take at the earliest onset of migraine pain best , but taking during aura phase <u>may</u> be too early. • If failure with one , can try another ^{fast vs slow; route} • Triptan + NSAID : benefit some ^{2?} recurrence= use ≤2x/wk • Frequent triptans use can cause rebound & chronic daily headache (Some clinicians suggest 10-18 doses/month ok ^{NIHB} ^{Max: 12/month; lack of data?}) •Less nausea vs DHE but ↑ recurrence rate SC IMITREX ⁴ {most effective triptan form @2hr: NNT=2; OK if nausea; but less convenient & ↑cost; useful for cluster type HA or alternate rapid triptan e.g. Zolmig nasal} •SC best bioavailability/fastest onset ~10-15min versus orals onset 30-120min: (nasal also fast! 15min) Nasal IMITREX & DF (age >12yr ⁵), MAXALT Wafer , &/OR ZOMIG RAPIMELT or nasal ⁴ may be preferred if • fast relief required nasal ~15min; melt tab 30min, & • nausea &/or vomiting present (wafer/melt: can take without water & inconspicuous) AMERGE ⁴ = slower onset 60-120min but • better tolerability, less drug interactions • longest duration, lowest recurrence rate (2.5mg less effective ⁶ : at 2hr vs riza 10mg & at 4hr vs suma 100mg) ⁶⁵	1mg or 2.5mg;  may repeat in 4h MAX=5mg/24h	50 generic /104
	Rizatriptan MAXALT, g  (5,10mg capsule shaped tab; 5,10mg wafer, g oral dissolving)						5mg or 10mg; may repeat in 2h MAX 20mg/24h	42 generic /107 ^{age >6yr FDA}
	Sumatriptan IMITREX, g  (25,50,100mg DF tab; -generic 25.50 & 100mg tabs 5,20mg Nasal spray ; 6mg/0.5ml SC inj); [50mg OTC in the UK; Sumavel DosePro 6mg/5ml: needle-free inj in USA; Treximet in USA, Suma 85mg + naproxen 500mg]						If With Propranolol: 5mg; 10mg/24hr 50-100mg PO ;  25-50mg may repeat in 2h (MAX 200mg/24h) 5mg or 20mg in <u>one</u> <u>nostril</u> ; may rpt in 2h (MAX 40mg/24h) 6mg SC ; may rpt x1 in 1h; (MAX 12mg/24h)	54 generic /105 103 210 generic /290
	Zolmitriptan ZOMIG, g  (2.5mg tab; 2.5mg ZOMIG Rapimelt tab, g); (5mg Nasal spray)						1.25mg or 2.5mg ;  may repeat after 2hr MAX 10mg/24h With Propranolol ↓ zolmi dose. 5mg nasal  switch to oral	38 generic /98 192
ERGOTS (5HT _{1B/D} , 1A _{1/2} , 2A _{2/3} , 3, α & β; DA _{1/2} Agonists)	Dihydroergotamine DHE MIGRANAL, g  (1mg/ml injectable) (4mg/ml nasal spray = 0.5mg / spray) NOTE: pump 4Xs into the air to prime nasal spray for 1 st use.		1st line agent for severe & ultra-severe attacks (for status migrainosus, ⇒ pre-dose antiemetic, e.g. metoclopramide, x2-3 days) CI •cardiac or cerebrovascular disease (or risk factors); uncontrolled hypertension, ?diabetes, pregnancy •hemiplegic or basilar migraine Caution: renal/hepatic dysfunction	Metoclopramide MAXERAN, REGLAN alone sometimes effective Chest discomfort, tingling & paresthesia, nausea, drowsiness, dizziness, diarrhea, muscle cramp. May cause/worsen Raynaud's. Nasal spray = rhinitis, taste disturbance but ↓ nausea • baseline cardiac evaluation/ECG recommended for ♂>40yr & ♀>50yr	• Do NOT use within 12hr of triptans or 24hrs for naratriptan ⁶ (risk of additive vasoconstriction/ coronary vasospasm) •↑ toxicity (eg. severe ischemia) of ergot preps with potent CYP 3A4 inhibitors : clarithromycin, erythromycin, propranolol, protease inhibitors & itra-, posa- & voriconazole. •Sibutramine: ↑ risk of serotonin syndrome. •p -porphyria concern	•Non-selective 5HT agonist: (also α, β & DA) • More nausea than triptans but less chest pain •May precede with 10mg metoclopramide, or prochlorperazine ^{5-10mg} esp. if severe attack requiring repeat doses or if nausea present • IV = rapid onset but more adverse effects so reserve for severe attack ⁶ (IV dihydroergotamine 5 days more effective than shorter ≤2day courses; effect up to 4wks. ¹⁵⁵) • SC = slower response rate vs IMITREX but longer acting & lower recurrence rate at 24hr ⁷ • Nasal spray =response rate similar to oral triptans, or nasal IMITREX ⁵ ; low recurrence rate	0.5-1mg q1h SC, IM or IV; repeat q1h to Max 3mg/24h ^{6mg/wk} {IV 1mg/50ml over ≥15min Refractory: 11.25mg total IV over 5day ¹⁵⁵ 1 spray into <u>each</u> nostril stat; repeat in 15 minutes prn MAX 4 spray/attack ; 6 sprays/24h (8 sprays/wk)	31 \$ 44 per 1 pkg (3 bottles X4 doses per bottle)
	Ergotamine/ X  caffeine (1/100tab ⁶) CAFERGOT Ergodryl, Ergomar SL & Cafergot-PB Supp – D/C'd by the company.		2nd line due to ↓ efficacy & ↑ toxicity CI •cardiac or cerebrovascular dx or risk factors, uncontrolled BP, ?diabetes, pregnancy/breastfeeding •hemiplegic or basilar migraine Caution: renal/hepatic dysfunction	Chest discomfort/ pain, tingling & paresthesia, nausea, vomiting, dizziness, drowsiness, diarrhea, muscle cramps. May cause/worsen Raynaud's. Chronic daily headache (with overuse; limit to 1-2 days/week)		•Non-selective 5HT agonist • Most nausea of all abortive preps ; recent meta-analysis ?'s efficacy as mainly appeared to ↑ N&V ⁸ • Ergotism with overuse: vasoconstriction⇒ numbness, tingling, paresthesia, blue hands/feet, (gangrene of extremities), HA, seizures, abdominal/chest pain, lack of pulse	2 tab po stat, then 1 tab Q30-60min, MAX 6tab/24h ; 10/wk	13
NONSPECIFIC ANALGESICS	NSAIDs  ASA, high dose, diclofenac K ⁺ Cambia powder X [®]  Ibuprofen , Naproxen Na ⁺ ANAPROX X [®]  or Naproxen (500mg Tab or Supp [®])		Treatment of mild-moderate attack CI •hypersensitivity to ASA/NSAID (ie bronchospasm, nasal polyps) Caution: CV/renal dx; ↑GI ulcer risk (Ibuprophen 400mg: NNT=3-4. ^{Cochrane Rev} Useful also for tension-type headache)	•GI irritation/upset/bleed, dizziness, fatigue, rash •Renal impairment esp. if CrCl <30ml/min See also NSAIDs chart for other drugs/formulations.	•↑ bleeding with warfarin & antiplatelet agents •May blunt effect of some antihypertensives •others •May displace DVA & older bnylureas so ↑ toxicity, but usually insignificant.	• Overuse (ie >10-15x/wk) can lead to rebound headache or medication-induced headache •for short-term, intermittent use: will increase effectiveness if used together with triptan ^{OTC} •Enteric ASA too slow. Buffered ASA OK •Fast acting useful (ie. ANAPROX, VOLTAREN RAPIDE X [®] , ibuprofen) •Ibuprofen effective & acetaminophen useful: kids [®]	ASA 650-1300mg po q4h X2 Ibuprofen 400-800mg po q4-6h X2 (MAX 3.2g/24h) ANAPROX 275-550mg po q4-6h X2 (MAX 1.65g/24h) Naproxen 500-1000mg po *Consider suppository if vomiting	\$1 (MAX 4g/24h) \$1 OTC 400mg \$15 \$2 (MAX 1.5g/24h) OTC 220mg
	292s, TYLENOL #3, FIORINAL X  X [®] , others Acetaminophen TYLENOL 		Treatment of mild-moderate attack if: •not relieved with simple analgesics •vasoconstrictors are contraindicated 1g sometimes effective NNT=12; better if taken early & with metoclopramide!	Drowsiness, dysphoria, nausea, constipation (esp. with codeine); {Opioids may ↑ risk of chronic HA}	•Products with ASA similar to above •Additive effects with other CNS depressants	• Overuse associated with rebound & medication induced headache (esp. caffeine combos); for short-term & intermittent use • Dependency potential •may mask pain without affecting underlying pathophysiology	1-2 tabs/caps stat; may repeat 3-4h prn MAX 6-8 tabs/caps per 24h	T3= \$ 8 292= \$ 8 Fc½= \$ 20
	Butorphanol X  10mg/ml nasal spray (previous STADOL) 1mg/spray		Reserve for rescue treatment or when DHE/triptans ineffective or contraindicated	Drowsiness, dysphoria, nausea & vomiting, nasal irritation (Dose ~ 1mg/spray)	•↑ CNS depression: CNS depressants, MAOIs, alcohol	• Dependency potential • Mixed agonist-antagonist so can precipitate withdrawal in persons addicted to opiates	1 spray in 1 nostril; may repeat in 3-5hr MAX 16 sprays/24h	\$60 (15 doses)
	CORONARY VASOSPASM Potential: still greatest concern; meta-analysis showed no clinically important differences between agents, thus one unlikely to be "safer" than others ⁹ : ⇒ patient selection & counselling important! (♀ with aura ↑ risk) Other/Adjunct: • metoclopramide MAXERAN 10-20mg SC/IV q8h (IV: in 50ml over ≥15min); 5-10mg PO • chlorpromazine 5-25mg IV (10-25mg PO) q4-6h (IV: pretreat with ≥500ml NS) • domperidone 20-30mg PO (or 60mg PR) tid-qid • prochlorperazine STEMETIL 5-10mg IV (25mg PR) q8h • dexamethasone 4-10mg IV x1; 8-24mg PO x1 • trimebutine MODULON 200mg cap po x1 (may ↑ Triptan efficacy with less nausea & photophobia. ⁴⁸) • haloperidol HALDOL 5mg IV in 500ml normal saline or 5mg IV over 3mins • diphenhydramine BENADRYL 25mg IV combined with prochlorperazine or metoclopramide IV x1 to ↓ akathisia. [Investigational] Telcagepant: cGPR antagonist; non-vasoconstrictive; ↑T1FT3; • O2 x15min: NNT=8.							

Migraine headache: consider if recurrent severe disabling headache assoc. with nausea & sensitivity to light & a normal neurological exam. Characteristically is unilateral >60%, asymmetrical, pulsating, builds up over minutes to hours, & aggravated by routine physical activity.
















MIGRAINE:

AGENTS FOR PROPHYLAXIS

most ↓ # of days &/or frequency of attacks +/- intensity

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





Jan 13

	Generic/ TRADE	PREGNANCY CATEGORY	INDICATIONS AND CONTRAINDICATIONS CI	SIDE EFFECTS	DRUG (DI) INTERACTIONS	COMMENTS	DOSING range / typical	\$  /month
TCAs	Amitriptyline ELAVIL /g (10, 25, 50, 75 ^x mg tab)		1st line especially if associated depression, chronic pain, insomnia, & tension-type headache {fluoxetine possibly effective in some.}	Anticholinergic: dry mouth, constipation, etc.; dizziness, drowsiness , postural hypotension, ↑weight (high drop out rate ~20% with amitriptyline)	Avoid with MAOI, cisapride, clonidine ↑ adverse effects for MAOI, anticholinergics, other CNS depressants ↑ effect with CCBs, SSRIs cimetidine, phenothiazines, cipro (↓ TCA metabolism)	•Central neuromodulator of noradrenaline & serotonin (5HT) system • Start low & titrate up to help ↓ side effects; may give single dose at bedtime {nortriptyline ~1.5-2x more potent than amitriptyline; less side effects, but also less trial evidence} • Cautions in elderly ⇒ anticholinergic effects	10-25-150mg/d 50mg po hs 100mg po hs	11-30 15 23
	Nortriptyline AVENTYL /g (10, 25mg cap)		CI •severe cardiac, kidney, liver, prostate or thyroid disease; glaucoma, hypotension •seizures •MAOI use	Nortriptyline ⇒ less drowsiness, dry mouth & weight gain than amitriptyline; but less evidence			10-150mg hs 50mg po hs 100mg po hs	11-38 18 28
β-BLOCKERS	Metoprolol LOPRESOR /g (25 ⁵ , 50 ⁵ , 100 ⁵ mg tab, SR 100, 200mg)		1st line option (especially in patients age <60, or those with hypertension or CVD) Can reduce frequency and some effect on intensity and duration.	Fatigue, bradycardia, hypotension, coldness of extremities, depression, impotence, sleep disturbance, bronchospasm	↑ levels of rizatriptan (↓ dose of riza to 5mg) ↑ risk of peripheral ischemia with ergots ↑ cardiovascular effects with CCBs, clonidine ↑ levels of β-blocker with cimetidine, fluoxetine Altered hypo-glycemic effect with sulfonylureas	•Modulation of central catecholaminergic system & brain serotonin •May be class effect however β-blockers with intrinsic sympathomimetic activity may not be effective (data from small/poorly designed trials) ¹⁰ • Atenolol 50-150mg/day & Nadolol 80-240mg/day also used.	Metopr 50-200mg/d 50mg po bid 100mg SR po od	10-16 15 12
	Timolol BLOCADREN/g (5 ⁵ , 10 ⁵ , 20 ⁵ mg tab)						Timolol 10-30mg/d 10mg po bid	18-32 29
	Propranolol INDERAL /g (10 ⁵ , 20 ⁵ , 40 ⁵ , 80 ⁵ & 120 ⁵ mg tab; LA 60, 80, 120, 160mg)		CI •asthma, heart block or uncompensated heart failure, peripheral vascular disease			• Start low & titrate up q1-2 weeks •If failure with one → may try another β-blocker •Taper slowly before stopping to prevent rebound	Propran 80-320mg/d Initial: 20mg bid 80mg po bid 120mg LA po od	10-15 /82 ^{LA} 12 39
CCBs	Flunarizine  SIBELIUM /g (5mg cap) Discontinued		↓ frequency; little effect on intensity or duration. Tolerance may develop. CI • HF, arrhythmias, hypotension (pregnancy with flunarizine) Caution: β-blockers, Parkinsons Verapamil ~1 st line option expert opinion	Flunarizine: fatigue, weight gain, depression , parkinson like side effects (EPS) Verapamil: bradycardia, hypotension, constipation , nausea, edema, headache	↑ effect of CNS depressants Verapamil = many DIs (CYP 3A4 inhibitor). ASA, barbs, β-blockers, carbamazepine, cimetidine, digoxin, erythromycin, ketoconazole, lithium, statins & theophylline	•? modulate transmitters rather than vasodilation • Maximum effect may take several months •Overall benefit similar to β-blockers •Verapamil often used but less studied •Verapamil good prophylaxis → cluster headache [Flunarizine seldom used/discontinued (probably effective in kids ⁵);]	5-10mg/d 5mg po hs (>6yrs old) 10mg po hs starting dose	DC'd 31 55
	Verapamil ISOPTIN , others (120, 180 ⁵ , 240 ⁵ SR tab/cap)						240-320mg/d 240mg SR po od (higher doses in cluster HA?)	30
ANTICONVULSANT	Divalproex (DVA) EPIVAL /g (125, 250, 500mg) EC tab; 1000mg/10ml vial ^x (⊗)		1st line for severe migraine (↓ severity, duration; ↓ 50% ^{NNT=2.5}) but little effect on mild-moderate attacks; •useful for SSRI induced migraine, prolonged atypical migraine aura & migraine with vertigo topiramate 50mg/day	DVA: Common: nausea 1 st 6mo, tremor, wt gain, alopecia, ↑LFTs, drowsy, diarrhea (transient, best if start low & titrate up) dizziness; polycystic ovary. Rare: ↓ platelets (↓ dose helps) & WBC , hepatotoxic, skin rx's, pancreatitis, hyperammonemia. Neural tube defects ^{Pregnancy} → spina bifida 1-2%. Suicidal ideation NNH <500 [Topiramate drop-out rate: ~30%]	↑ ASA & warfarin effect ↑ Valproic acid level by: ASA, cimetidine, erythromycin, fluoxetine, isoniazid & salicylates ↓ Valproic acid level by: carbamazepine, cholestyramine, lamotrigine, phenobarbital, phenytoin, primidone, rifampin & topiramate Valproic acid ↑ levels of: amitriptyline, carbamazepine epoxide (ie. ↑ SE), clonazepam, diazepam, lamotrigine lorazepam, phenobarbital & warfarin	Anticonvulsants: effective NNT=3.8, AE's common SE=DC: NNH=24-33 ¹⁹ • Divalproex less GI effects than valproic acid [Divalproex 250mg OD x7d, then 250mg BID x7d, then 250mg AM + 500mg HS x7+ d] •Monitor LFTs initially: if ↑ enzymes, then ↓ dose; if 2-3x normal → stop drug; Mech: Modulation of GABA receptors? Gabapentin ?? ineffective @ <2,400mg/day (Gabapentin & Topiramate are Peds options – see antiepileptic chart for dosing) Topiramate effective 11,12,13,14; 100mg/day equal to propranolol 160mg/day ¹⁵ ; expensive but generic avail; SE's common (e.g. paresthesias, cognitive, taste, anorexia, fatigue, wt loss). Lamotrigine -ineffective migraine prevention! AAN ¹²	500-1500mg/d 125mg po bid cc 250mg po bid-tid cc 500mg bid cc with meals	15 18-26 30
	Gabapentin NEURONTIN (100, 300, 400mg cap) (600 ⁵ , 800 ⁵ mg tab ^x ↑↑\$)		CI •liver disease Caution: children → hepatotoxicity Monitor: CBC, Platelets, LFT (Level 350-830 umol/l – trough) -see comments column & antiepileptics chart p 85				{Initiate: 300mg tid} 600-800mg po tid	41 75-91
	Topiramate TOPAMAX (25, 50, 100, 200mg tab; 15, 25mg sprinkle cap)						{Initiate: 25mg po hs, ↑ by 25mg/wk} 50-100mg po bid (may give 100mg at HS to ↓ SE)	22 ^{generic} 74-77
5HT ₂	Pizotylene/pizotifen SANDOMIGRAN (0.5mg, DS = 1 ⁵ mg tab)		2nd line (seldom used). CI •?diabetes, heart disease, glaucoma, urinary retention, prostatic hypertrophy, renal/hepatic dysfx	Weight gain, fatigue, weak anticholinergic effects	Additive effects with: CNS depressants, anticholinergics	•Serotonin-2 receptor antagonist •Somnolence so begin low & dose at bedtime (ie 0.5mg hs).	Start 0.5mg po hs titrate to 0.5mg tid (or 1.5mg po hs). MAX 6 mg/day	20 47 1mg tid ⁷⁰
ERGOTS	Methysergide SANSERT (2mg tab )-D/C by Co		3rd line - for prevention of severe recurrent migraine unresponsive to other agents (seldom used) CI •hypertension, cardiac, liver, kidney, lung & collagen dx; ^{porphyria concern.} •thrombophlebitis & pregnancy	Retroperitoneal, cardiac & pulmonary fibrosis ⇒ do not use for >6 months duration without weaning & a 1-2 month drug holiday! Nausea, muscle cramps, ↑ weight, ↓ hair, claudication, hallucinations	•Do NOT use within 24hr of triptans (risk of ↑ vasoconstriction/spasm) ↑ toxicity of ergots with: clarithromycin, erythromycin, propranolol & protease inhibitors	•Serotonin-2 receptor antagonist with carotid vasoconstrictor effect •Active metabolite •If no effect after 3 week trial, not likely to help •Taper dose over 2-3 weeks before stopping!	2-8mg/d 2mg po bid cc 2mg po tid cc	76 110

OTHER: candesartan ATACAND 16mg/day Norway trial; (or lisinopril 20mg/day), venlafaxine EFFEXOR XR 75mg-150mg/day (similar to TCAs, less evidence, less anticholinergic); **Coenzyme Q10** 75mg BID -100mg TID. •Acupuncture?¹⁸; Spinal manipulation?¹⁹
riboflavin Vit B2 400mg/d⁵¹⁰, **magnesium** citrate = 500mg/d⁵¹⁰, feverfew TANACET considered ineffective, **butterbur** (petasites) extract PETADOLEX ≤ 75mg bid¹⁶ •**BOTOX** inj 25-155 IU ~q3mon¹⁷, CDN11/FDA¹⁰⁷ (for chronic daily HA & chronic migraine but NOT chronic tension or episodic migraine) Jackson 12, CADTH-86
NSAIDs: some evidence for benefit with naproxen na+; ✓ menstrual migraine. Frovatriptan intermittent for prevention of menstrual migraine: used q12h short-term starting 2days prior to onset of period. [Note: Botox may not be effective for those with less than 15 HA days/mo]

PROPHYLACTIC THERAPY should be considered if: •migraines severe enough to impair quality of life or patient has ≥ 3 severe attacks per month which fail to respond to abortive therapy.

TIPS: •use one agent at a time •**start low & titrate up**; once effective dose reached, continue for **minimum 3 month trial** to evaluate effectiveness (benefits usually seen after 1-2 months) • efficacy depends on **withdrawal of analgesics** causing rebound or chronic daily headache •if refractory to single agent, may try **dual therapy** (eg. beta blocker + TCA) if refractory; consider neuro consult if no response •continue effective tx for **9-12mon** or indefinitely
 if severe/recurrence: •**discontinue gradually** to prevent rebound •before NSAID/triptan consider metoclopramide or domperidone •in some ♀ **long cycle continuous birth control pills** can help ↓ migraines but may avoid OCs if aura (↑risk).
 •**Success of prophylaxis** considered to be ↓ in severity or frequency of headache by 50% •reassess in teens (eg nearly 40% of teens esp if no migraine family history, no longer had headaches 10 yrs later Monastero 2006)

CI=contraindication **CNS**=central nervous system **DI**=drug interaction **LFT**=liver function test **SE**=side effect **SR**=sustained release. **x**=Non-formulary in SK =EDS status SK =covered NIHB =not NIHB =prior NIHB =scored tab =↓dose for renal dysfx

Migraine headache: prevalence peaks in midlife, ~12% of population affected, with females 3-4 times more often than males, 5-10% of children & adolescents, & 1/3 experience an aura (flashing lights, numb/tingle in face/extremities, disturbed smell or difficulty speaking).

Approach to Migraine: Considerations

- ♦ ACUTE: - may consider metoclopramide or domperidone ^{1st}; NSAID and/or triptan also recommended first line;
 - in very severe attacks, SC sumatriptan likely to be most effective & rapid; consider need for rapid onset vs recurrence, GI tolerance of po form, etc.
 - Link to Review Article in AFP Feb 2011: <http://www.aafp.org/afp/2011/0201/p271.html>
- ♦ PROPHYLAXIS: 1st line: beta-blockers (propranolol, metoprolol), TCAs, valproic acid, topiramate.
- ♦ MENSTRUAL Related Migraine (MRM): - severity may be increased; duration of headache may be longer and may be harder to treat than regular migraine
 - may consider NSAID or triptan for short-term treatment, several days before and during menstruation ²⁰.

Agents not effective or too many side effects:

- ♦ SSRIs, clonidine, methylsergide, oxcarbazepine, melatonin

References: RxFiles – MIGRAINE AGENTS

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