

A

Migraine Clinical Care Path: Diagnosis

Key Questions

Patient Interview

- Age at onset of headaches, frequency, duration?
- Do your headaches interfere with your life?
- In what part of your head do you feel pain?
- What symptoms do you have during an attack?
- Are there triggers for your headaches?

Review Signs and Symptoms With Patient

Signs and Symptoms History

Key Migraine Signs and Symptoms¹⁻³

- Recurrent, episodic headache
- Disabling headache lasting 4–72 hours
- Must have any 2 of the following:
 - Unilateral location
 - Pulsating quality
 - Moderate or severe pain intensity
 - Aggravated by movement
- Must have either one of these associated symptoms:
 - Light and/or sound sensitivity
 - Nausea and/or vomiting
- Must have had at least 5 attacks filling the above criteria
- Other common symptoms may include:
 - Rhinorrhea, nasal congestion, lacrimation, sinus area pain, neck discomfort or pain
- Clinical attributes that may correlate with migraine²:
 - Headache associated with menstrual cycle
 - Family history of similar symptoms
 - Headache preceded by aura (in some cases)

Red Flags Not Usually Associated With Migraine²

- “Thunderclap” headache
- Change in headache pattern
- Fever or systemic symptoms
- Focal neurologic findings
- Onset age >50 years
- De novo in peripartum period
- Precipitated or exacerbated by positional changes, valsalva, bending, or coughing
- Escalating medication requirements
- History of cancer, immunocompromise, or HIV

Abnormal Medical Findings Not Usually Associated With Migraine⁴

General Physical Exam

- Fever
- Hypertension
- Chronic malaise
- Myalgia
- Arthralgia
- Weight loss
- Tender, poorly pulsatile temporal arteries
- Other abnormal physical exam

Abnormal Neurologic Findings Not Usually Associated With Migraine^{2,4}

Neurologic Exam

- Drowsiness
- Confusion
- Ataxia
- Signs of meningeal irritation, including neck rigidity
- Progressive visual or neurologic changes
- Focal neurologic signs or symptoms, such as papilledema, motor weakness, memory loss, pupillary abnormalities, or sensory loss
- Other abnormal neurologic exam

Is This Migraine?

no

yes

Go to Side B

Evaluate for Other Primary Headache
tension-type, cluster, other

Evaluate for Secondary Headache
Such as serious underlying neurologic condition (eg, brain tumor, hemorrhage, temporal arteritis)

B Migraine Clinical Care Path: Management

Make or Confirm Migraine Diagnosis (ICD-9-CM 346)

Assess Frequency, Severity, and Disability (Consider use of HIT-6™ and Headache Diary)¹

Assess Management Needs and Set Goals

Suggest Self-Care Techniques and Create Action Plan With Patient

Initiate Pharmacologic Management

Acute Therapy

For optimal pain relief, provide early intervention and encourage treatment at the first sign of pain. Stratify therapy based on intensity/disability.^{2,3}

Goals^{4,5}:

- Rapid and complete pain relief
- No recurrence of migraine symptoms
- Restored ability to function normally

Mild to Moderate Intensity/Disability^{2,3}

- Analgesics, NSAIDs
- Self-care techniques

Severe Intensity/Disability^{2,3}

- Migraine-specific therapy, NSAIDs, and antiemetics
- Self-care techniques

Note: To minimize the risks of medication overuse headache, abuse, and dependence, reserve opioid use for those who fail to respond to nonopioids, or are intolerant of or have contraindications to them.³

Monitor for Medication Overuse

- To help avoid risks such as medication overuse headache or GI/liver/kidney dysfunction:
 - Prescribe appropriate doses
 - Limit acute therapy use to less than 15 days/month for analgesics and less than 10 days/month for opioids, ergotamines, and triptans³

Reevaluate Treatment If:

- Inadequate relief
- Medication overuse occurs
- Continued disability
- Unacceptable side effects

Preventive Therapy³

Goal: At least a 50% reduction in headache frequency, and a reduction in migraine severity and duration^{3,5}

Reasons to Consider Preventive Therapy Include³:

- Headache frequency >2 days per week (or >8 days per month) with disability ≥3 days per month
- Headache disability persists despite aggressive acute intervention
- Reoccurring migraines interfere with daily routine
- Presence of prolonged or complex aura (>1 hour) or migraine-induced stroke
- Acute medications fail, are overused, or cause adverse reactions
- Patient's desire to reduce migraine frequency

Approach³:

- Consider comorbid conditions in drug selection
- Use titration to achieve a therapeutic dose
- Most clinicians recommend 6-12 months maintenance once a greater than 50% reduction in headache frequency occurs, followed by a tapering phase

Initial Follow-up (Consider use of HIT-6™ to assess disability)

Continue Current Care

Adjust Treatment Plan

Consider Consult or Referral

Periodic, Long-term Follow-up

References: 1. Headache Impact Test™ (HIT-6™). www.headachetest.com. Accessed January 22, 2009. 2. Taylor F, et al. *J Fam Pract*. 2004;(suppl):S2-S23. 3. National Headache Foundation. *Standards of Care for Headache Diagnosis and Treatment*. Chicago, IL: National Headache Foundation; 2008. 4. Lipton RB, et al. *Headache*. 1999;39(suppl 2):S20-S26. 5. Silberstein SD for the US Headache Consortium. *Neurology*. 2000;55:754-762.

This material was developed by GlaxoSmithKline.