CLINICAL PRACTICE BRIEF:
GUIDELINE FOR PRIMARY CARE MANAGEMENT OF HEADACHES IN ADULTS

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Toward Optimized Practice (TOP) of Alberta, Canada, provides multidisciplinary clinical practice guidelines that are based on evidence-based practice. These guidelines include recommendations on counseling, diagnosis, evaluation, management, prevention and treatment for primary headache disorders.

Primary headache disorders are not due to another medical condition, and they include primarily migraine and tension-type headaches. The target population for this guideline is adults aged 18 or older who experience primary headache disorders. These guidelines outline "dos and don'ts" for providers as well as pharmacological and non-pharmacologic interventions based on evidence. The health care practitioner should consider these recommendations within the context of patient preferences and sound clinical decision-making.

Several of the Practice Recommendations Include:

- For the patient presenting with headache for the first time or with a significant change in headache pattern:
  - The headache history should include information on headache onset, duration of attacks and the number of days per month or week with headache; pain location; pain quality; hormonal factors; associated symptoms; aura symptoms; precipitating factors; severity and impact on function; acute and preventive medications used and response; and presence of co-existent conditions.
  - Patients should have a physical examination that includes 1) a screening neurological examination with attention to cranial nerves and fundoscopic exam; 2) a neck examination; 3) a blood pressure measurement; 4) a focused neurological examination, if indicated; and 5) an examination for temporomandibular disorders, if indicated.
  - Patients with new onset headache should be evaluated for emergency and urgent red flag symptoms
    - Emergent red flag symptoms include thunderclap headache (i.e., pain reaching peak intensity within seconds to minutes), headache with fever and neck stiffness (i.e., meningismus), papilledema with altered level of conciseness and/or focal neurological signs and acute angle-closure glaucoma.
    - Urgent red flag symptoms include signs of systemic illness in patients with new onset headache, new headache in persons aged 50 or above with symptoms suggestive of temporal arteritis, papilledema in an alert patient without focal neurological signs and new onset headache and subacute cognitive change in an elderly patient.
- Clinicians should monitor for medication overuse. Medication overuse can occur in patients taking ibuprofen or acetaminophen 15 or more days per month, triptans 10 or more days per month and 10 or more days per month of any combination of triptans, analgesics or opioids for more than three months.
- Comprehensive migraine therapy includes the management of lifestyle factors and triggers, acute and prophylactic medications and migraine self-management strategies.
- Some lifestyle factors have the potential to increase migraine frequency. Although scientific study of these factors and their effects has been limited, the following are considered important by many clinicians:
  - Irregular meals or skipped meals.
  - Irregular sleep or too little sleep.
  - A stressful lifestyle.
  - Excessive caffeine consumption.
  - Lack of exercise.
  - Obesity.
- Most patients with migraine report several specific factors that increase the likelihood that they will have a migraine attack. These are commonly referred to as triggers. Some triggers can be avoided or managed. Refer to the TOP patient handout Food Triggers, Caffeine and Migraine Attacks for more information.
- Encourage patients to keep a headache diary to monitor headache frequency, intensity, triggering factors and medication use. Refer to the patient handout Headache Diary Sheet for more information. The degree of migrainerelated disability present should be assessed clinically. Health care practitioners may find formal disability scales helpful in selected patients. Learn more with the Headache Impact Test (HIT-6) and the Migraine Disability Assessment Scale (MIDAS).
- Assessment of patients with migraine should include a clinical evaluation for the presence of significant depression and/or anxiety. If present, these should be treated according to evidence-based mental health recommendations.
- Routine imagining is not recommended.

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Acute Pharmacological Migraine Treatment

- Triptans are the first-line medications for acute migraine treatment.
- Patients who have failed acetaminophen and NSAIDs should be offered triptans for acute migraine treatment.
  - Triptans can be used in combination with NSAIDs or acetaminophen. Additional triptan dosing in two hours should be encouraged if symptom reduction has not occurred.
- Opioid-containing analgesics are not recommended for acute migraine treatment.
- Butalbital-containing combination analgesics are not recommended for migraine treatment.

Preventive Migraine Therapy

- The goal of treatment is to reduce migraine frequency and severity by 50% to 80%.
- First-line preventive migraine medications include propranolol, amitriptyline topiramate, nadolol and nortriptyline. Family planning should be addressed when prescribing these agents.
- Onabotulinumtoxin A is only indicated for chronic migraine (i.e., 15 headache days per month with eight days being migraine-type headache).
- Nonpharmacologic compounds can also be used to prevent migraine attacks. These options include riboflavin, magnesium citrate and co-enzyme Q10. Please refer to the medication tables in the Guideline for Primary Care Management of Headache in Adults for more detail on drugs and dosages.
- Selective serotonin reuptake inhibitors are not recommended for migraine prophylaxis.

Nonpharmacological Therapy for Migraine and Tension-type Headache

- Options include cognitive behavior therapy, biofeedback, relaxation training, therapeutic exercise and acupuncture.
- Clinicians should monitor for medication overuse.

References:

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This Practice Brief was developed by an American Association of Nurse Practitioners® (AANP) workgroup collaboration between the AANP Practice Committee and AANP Specialty Practice Group (SPG) co-chairs. Last updated in 2019.

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