TREATMENT

Current Clinical Approach: Migraine

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What is migraine?

Migraine, a neurological disease, affects an estimated 2.7 million Canadians.[1] Migraine attacks are debilitating and impact quality of life. Individuals with migraine report missing work, school, and social events.[1] NPs are well positioned to address the care needs of people with migraine. Our scope of practice allows us to provide full spectrum treatment from diagnosing this disease, to prescribing the necessary pharmacological treatment to patients with migraine. The foundational piece that NPs can offer is a patient-centred approach to lifestyle and education tailored to an individual's unique lived experience.

How do you diagnose migraine? What does a patient with migraine look like?

Migraine, while common, is underdiagnosed. Some estimates report that only 40% of those with migraine receive an accurate diagnosis.[1] The problem with underdiagnosis is that it leads to suboptimal treatment and undue disability due to a lack of access to appropriate prescription treatments. A Health Canada survey found only 42% of people with migraine had been treated with a prescription medication.[1]

One quick, simple tool to help with migraine diagnosis is the Lipton 3-item ID migraine screener. Answering yes to 2 of the 3 questions gives a 93% positive predictive value.[2]

3-Item ID migraine screener

During the last three months, did you have any of the following with your headaches?	
Item	**Yes / No**
You felt nauseated or sick to your stomach when you had a headache?	Yes ☐ No ☐
Light bothered you (a lot more than when you don't have headaches?)	Yes ☐ No ☐
Your headaches limited your ability to work, study or do what you need to do for at least one day?	Yes ☐ No ☐

Lipton RB et al. Neurology. 2003;61(3):375–382.

Symptom variability in migraine

Patients with migraine can present with a wide range of symptoms and severity. This diversity in presentation can make a migraine diagnosis more challenging. When a patient visits their healthcare provider for headache symptoms, it is likely because their function is impacted. Migraine is a clinical diagnosis so it is important to ask clear questions about their headache features. Once red flags are ruled out, a headache that is impacting routine function is a diagnostic feature of migraine.

One common misconception is that a migraine attack always presents as a unilateral headache.

In reality, up to 40% of migraine attacks may be bilateral in presentation. Neck pain is another symptom that is extremely common, present in 70-80% of all migraine attacks, but is often misconstrued as a symptom of a tension headache.

What are the goals of treatment?

The goals of migraine treatment are to restore function and provide sustained pain relief with minimal side effects. An effective acute treatment should stop the migraine attack and prevent recurrence. Patients should be regularly re-assessed to ensure their treatment is optimized and migraine attack frequency is not increasing. This is important as untreated acute migraine attacks could unnecessarily persist for hours to days. Over time, the frequency of attacks can increase and evolve into chronic migraine.

What to do when OTC treatment fails? What do you start with?

First-line treatment options recommended by the Canadian Headache Society (CHS) for mild to moderate migraine attacks are acetaminophen or NSAIDs.[3] By the time most people with migraine seek care they have already tried and failed OTC treatments. Prescription NSAIDs are the next option to try – such as naproxen sodium or diclofenac potassium in tablet formulations. Diclofenac potassium is also available as a novel buffered oral solution that has a time to maximum plasma concentration (T_{max}) of approximately 15 minutes, suggesting the potential for a rapid onset of effect.[3]

For moderate to severe migraine attacks or when NSAIDs alone have failed, the CHS recommends an NSAID with triptan rescue or triptan alone.[3] There are currently 7 different triptans on the market and one combination triptan/NSAID. There is no clear data for superiority of one triptan over another and the patients should try different triptans if the initial treatment goals are not achieved.

For patients who are not achieving consistent resolution of their migraine attack with monotherapy or a single acute medication, they may need a combination of acute medications.

The combination of an NSAID and triptan can be useful in this setting. These can be taken as a separate triptan and NSAID or in the combination format of Suvexx (sumatriptan/naproxen).

How to trial a triptan:

- **Optimize efficacy of triptan**
  - Counsel patients to treat early in the migraine attack
  - Trial for at least 3 attacks to determine effectiveness

> “The best triptan choice is the one that works for the patient.”

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CLINICAL PEARLS

- Migraine diagnosis is key – If you aren't diagnosing migraine, your patient will never get appropriate pharmacological treatment
- When it comes to avoiding medication overuse headache, all days of acute medication use count – don't forget to ask about OTC use!
- Migraine is often misdiagnosed and is the most common primary headache to present
- The best triptan choice is the one that works for the patient
- Patient education is key on how to take their medications – timing and appropriate use

Timing of treatment

It is essential to teach patients how to best use their acute medications. The most common mistakes are waiting too late to take their medication or using less effective options first.[3] The earlier a migraine attack is treated, the higher the likelihood the migraine will be successfully treated.

Medication overuse headache

All patients with migraine should be counselled on the risk of medication overuse headache. This can occur when a patient is taking more than 10 days of a triptan or 15 days of NSAIDs per month. It is important to always ask about all medication used to treat their headaches and migraine attacks as patients may forget to report OTC use. Having patients track the frequency of all headache days as well as acute medication usage will help the NP to develop an effective treatment plan and see patterns suggestive of migraine chronification or medication overuse.

1. Ramage-Morin, P. L., & Gilmour, H. Prevalence of migraine in the Canadian household population. 2014 Statistics Canada, available online at: https://www150.statcan.gc.ca/n1/pub/82-003-x/2014006/article/14033-eng.pdf
2. Lipton RB et al. Migraine prevalence, disease burden, and the need for preventive therapy. Neurology. 349
3. Canadian Headache Society Acute Migraine Treatment Guideline Development Group, Canadian Headache Society Acute Drug Therapy for Migraine Headache, Can J Neurol Sci 2013;40(suppl 3) S1-S80.