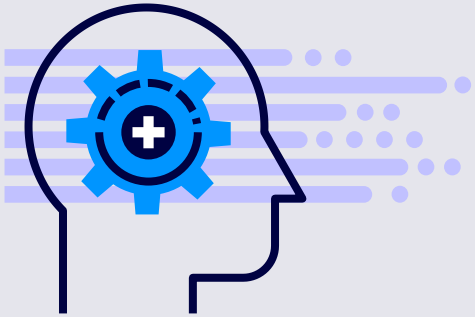
Pfizer Medical Affairs

Home

Diagnosis and Treatment of Migraine



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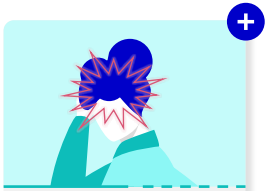
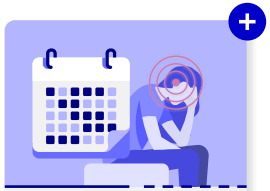
Diagnosis and treatment of migraine

The ICHD-3 provides diagnostic criteria for 3 main categories of migraine[1]

Migraine *without* aura



Migraine *with* aura



Chronic migraine

Differential diagnoses for migraine include other primary headache disorders and some potentially life-threatening secondary headache disorders[2]

Distinguishing typical characteristics of migraine include[1,2]:

- Unilateral location
- Accompanying symptoms
- Pulsating pain (moderate to severe)
- Aggravation by physical activity

Pharmacological treatment of migraine involves both acute and preventive therapies[2,3]

Acute treatment:

For all patients with a confirmed diagnosis of migraine[3]

Goals include[3]:

- Provide rapid symptomatic relief without recurrence
- Restore functioning

Preventive treatment:

For patients whose attacks significantly interfere with daily routines despite acute treatment; for those who have frequent attacks, intolerance or contraindication(s) to acute treatments or failure or overuse of acute treatments; or based on patient preference[3]

Goals include[3]:

- Reduce attack frequency, severity, duration, and disability
- Improve responsiveness to acute treatment

ICHD-3, International Classification of Headache Disorders, 3rd Edition.

1. Headache Classification Committee of the International Headache Society. The International Classification of Headache Disorders, 3rd edition. Cephalalgia 2018;38:1–211; 2. Martin VT, et al. Ann Med 2021;53:1979–90; 3. Ailani J, et al. Headache 2021;61:1021–39.

Diagnosis and treatment of migraine

Diagnosis of migraine *without* aura

History of ≥5 attacks fulfilling the following criteria[1]:

Headache attacks lasting **4–72 hours**

(when untreated or unsuccessfully treated)

With ≥2 of the following characteristics:

- Unilateral location
- Pulsating quality
- Moderate or severe pain intensity
- Aggravation by or causing avoidance of routine physical activity[a]

Accompanied by ≥1 of the following symptoms:

- Nausea and/or vomiting
- Photophobia and Phonophobia

Not better accounted for by another ICHD-3 diagnosis

[a]e.g, walking or climbing stairs.

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1. h
2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.

Diagnosis and treatment of migraine

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Not better accounted for by another ICHD-3 diagnosis

Patients may report **prodromal symptoms up to** 48 hours before the onset of headache

These may include:

hyperactivity | hypoactivity | depression | specific food cravings | yawning | fatigue | difficulty concentrating | neck stiffness/pain | blurred vision | sensitivity to light and sound

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Diagnosis and treatment of migraine

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Not better accounted for by another ICHD-3 diagnosis

Although pain is typically unilateral, **~4 in 10 patients** report bilateral pain during migraine attacks[2,3]

[a]e.g., walking or climbing stairs.

1. Headache Classification Committee of the International Headache Society. The International Classification of Headache Disorders, 3rd edition. Cephalalgia 2018;38:1–211; 2. Evans RW. Pract Neurol 2014:26–32; 3. Rasmussen BK, Olesen J. Cephalalgia 1992;12:221–8.

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Diagnosis and treatment of migraine

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Not better accounted for by another ICHD-3 diagnosis

Attacks can also be associated with **cranial autonomic symptoms** (e.g., lacrimation and nasal congestion) and **cutaneous allodynia**

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Diagnosis and treatment of migraine

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Not better accounted for by another ICHD-3 diagnosis

Migraine without aura is the disease most prone to **accelerate to chronic migraine** with frequent use of symptomatic medication

It can also **coexist** with migraine with aura and menstrual migraine[a]

When a patient fulfils criteria for >1 subtype of migraine, **each subtype of migraine diagnosed should be individually documented**

[a]Attacks occurring on days –2 to +3 of menstruation in at least 2 out of 3 menstrual cycles and at no other times of the cycle.

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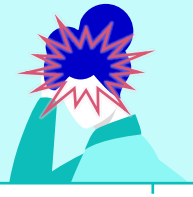
Diagnosis and treatment of migraine



Diagnosis of migraine *with* aura[a]

History of ≥2 attacks fulfilling the following criteria:

At least 1 of the following fully reversible aura symptoms:

- Visual
- Sensory
- Speech and/or language
- Motor
- Brainstem
- Retinal

At least 3 of the following characteristics:

- ≥1 aura symptom that spreads gradually over ≥5 minutes
- ≥2 aura symptoms that occur in succession
- Each individual aura symptom lasts 5–60 minutes
- ≥1 aura symptom is unilateral[b]
- ≥1 aura symptom is positive, e.g., scintillations or pins and needles
- The aura is accompanied or followed by headache (within 60 minutes)

Not better accounted for by another ICHD-3 diagnosis

Transient ischemic attack excluded

[a]Migraine with aura can be subcategorized as typical aura, brainstem aura (≥2 brainstem symptoms, e.g., dysarthria, vertigo, tinnitus, hypacusis, diplopia, ataxia, decreased consciousness), hemiplegic migraine (motor weakness) or retinal migraine (monocular visual disturbances); [b]Aphasia is always unilateral while dysarthria may or may not be.
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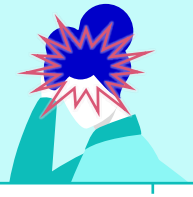

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- ≥1 aura symptom is positive, e.g., scintillations or pins and needles
- The aura is accompanied or followed by headache (within 60 minutes)

Not better accounted for by another ICHD-3 diagnosis

Transient ischemic attack excluded

~40% of people with migraine experience aura, either with every attack or some attacks[2]

Aura most commonly manifests visually[1–3]

>90% *of those affected*

and as other sensory symptoms[1,3]

~31% *of those affected*

[a]Visual aura often appears as a fortification spectrum near the point of fixation that may spread left or right gradually and leave relative scotoma in its wake. Scotoma without positive phenomena may also occur. Sensory disturbances take the form of pins and needles that move slowly from the point of origin and affect one side of the body, face and/or tongue. Numbness may follow or be the only symptom.[1]

1. Headache Classification Committee of the International Headache Society. The International Classification of Headache Disorders, 3rd edition. Cephalalgia 2018;38:1–211; 2. Rasmussen BK, Olesen J. Cephalalgia 1992;12:221–8; 3. Russell MB, Olesen J. Brain 1996;119:355–61.

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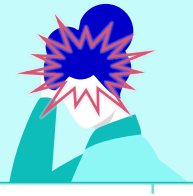
Diagnosis and treatment of migraine



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- ≥1 aura symptom is unilateral[a]
- ≥1 aura symptom is positive, e.g., scintillations or pins and needles
- The aura is accompanied or followed by headache (within 60 minutes)

Not better accounted for by another ICHD-3 diagnosis

Transient ischemic attack excluded

When 3 symptoms occur during an aura, the acceptable maximum duration is

3 × 60 minutes

Motor symptoms may last up to **72 hours**

[a]Aphasia is always unilateral while dysarthria may or may not be.

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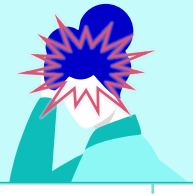
Diagnosis and treatment of migraine



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- The aura is accompanied or followed by headache (within 60 minutes)

Not better accounted for by another ICHD-3 diagnosis

Transient ischemic attack excluded

Aura symptoms can be **differentiated from transient ischemic attack (TIA)** symptoms by their gradual spreading and occurrence in succession versus sudden simultaneous onset in TIA

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1. h
2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.

Diagnosis and treatment of migraine

Diagnosis of *chronic* migraine

≥15 headache days per month for >3 months and fulfilling the following criteria:

At least 5 attacks meeting criteria for migraine without aura or migraine with aura

Any of the following on ≥8 days/month for >3 months:

- Features of migraine without aura
- Features of migraine with aura
- Believed by the patient to be migraine at onset and relieved by a triptan or ergot derivative

Not better accounted for by another ICHD-3 diagnosis

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Not better accounted for by another ICHD-3 diagnosis

2.5% of patients with episodic migraine transform to chronic migraine each year[2]

Conversely, reversion to episodic migraine can also occur[3]

1. Headache Classification Committee of the International Headache Society. The International Classification of Headache Disorders, 3rd edition. Cephalalgia 2018;38:1–211; 2. Bigal ME, et al. Headache 2008;48:1157–68; 3. Serrano D, et al. J Headache Pain 2017;18:101.

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Not better accounted for by another ICHD-3 diagnosis

When medication overuse is present,[a] both chronic migraine and medication overuse headache should be diagnosed

[a]Defined as use of ergotamines, triptans, opioids or combination analgesics on ≥10 days per month for >3 months, or nonopioid analgesics for ≥15 days per month for >3 months.
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1. h
2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.

Diagnosis and treatment of migraine

Differential diagnoses: Characteristics of primary headache disorders

Migraine[1]

Headache characteristics:

Usually unilateral in location

4–72 hours

Moderate or severe intensity

Usually pulsating pain

Accompanying symptoms:

Photophobia, phonophobia, nausea, vomiting

Often aggravated by routine physical activity

Tension-type headache[1]

Headache characteristics:

Typically bilateral or circumferential

Hours to days[a]

Mild or moderate intensity

Usually pressing or tightening pain

Accompanying symptoms:

Often none; sometimes photophobia or phonophobia (but not both); sometimes mild nausea in chronic tension-type headache

Not aggravated by routine physical activity

Cluster headache[1]

Headache characteristics:

Strictly unilateral and orbital, supraorbital, and/or temporal

15–180 minutes

Severe or very severe

Overwhelming pain

Accompanying symptoms:

Ipsilateral to the headache: cranial autonomic symptoms, e.g., conjunctival injection,[b] lacrimation (tearing) and nasal congestion

Associated with restlessness or agitation

[a]Or unremitting; [b]Increased redness of the eye due to enlargement of conjunctival vessels.[2]

1. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 2. Park IK, et al. Invest Ophthalmol Vis Sci 2013;54:5249–57.

Secondary headache disorders >

1. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.

Diagnosis and treatment of migraine

Differential diagnoses: Red flags indicating secondary headaches warrant further investigation, as demonstrated by the "SNOOP4" mnemonic[1,2]

Red flag sign or symptom	History and examination findings	Secondary headache causes	Diagnostic workup
Systemic	• History of HIV, immunosuppression or malignancy • Signs of infection (e.g., fever, chills, weight loss)	• Infection • Malignancy • Rheumatic disease • Giant cell arteritis	• Neuroimaging • Lumbar puncture
Neurologic	• Abnormal neurologic examination • Change in behavior or personality	• Malignancy • Infection • Inflammatory disorder	
Onset (sudden)	• Headache reaching peak intensity in <1 minute (thunderclap)	• Subarachnoid hemorrhage • Stroke • Reversible cerebral vasoconstriction syndromes	• Head CT • Lumbar puncture (if CT negative)
Older age at onset	• New onset headache at age ≥50 years	• Malignancy • Infection • Giant cell arteritis	• MRI
Pattern change	• Change in headache pattern or characteristics • Progressive headache (loss of headache-free periods)	• Malignancy • Inflammatory or vascular disorder	
Precipitated by Valsalva maneuver	• Headache precipitated by Valsalva maneuver, sneezing, coughing or exercise	• Chiari malformation type 1 • Posterior fossa lesions • Malignancy • Arachnoid cysts • Subdural hematoma • Intracranial hypertension or hypotension	• Neuroimaging
Postural	• Headache precipitated or aggravated by postural change	• Intracranial hypertension • Intracranial hypotension	• Neuroimaging • Lumbar puncture • MRI with gadolinium (to rule out dural enhancement with suspected CSF leak)
Papilledema	• Papilledema, visual obscurations, diplopia or field defects	• Intracranial hypertension • Malignancy • Inflammatory disorder	• Thorough funduscopic examination

CSF, cerebrospinal fluid; CT, computed tomography; HIV, human immunodeficiency virus; MRI, magnetic resonance imaging.

1. Martin VT, et al. Ann Med 2021;53:1979–90; 2. Dodick DW. Semin Neurol 2010;30:74–81.

< Primary headache disorders

2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.

Diagnosis and treatment of migraine

2021 AHS Consensus Statement:

Goals of acute migraine treatment

1. Provide rapid symptomatic relief without recurrence
2. Restore function
3. Minimize the need for rescue medications or repeat dosing
4. Optimize self-care and reduce healthcare utilization
5. Minimize adverse events
6. Reduce overall treatment costs

AHS, American Headache Society.
The AHS Consensus Statement provides timely recommendations for clinicians and is not intended to be, and should not be understood or applied as, a Clinical Practice Guideline.
Adapted from: Ailani J, et al. Headache 2021;61:1021–39.

Acute treatments >

1. K
2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.

Diagnosis and treatment of migraine

Acute treatment of migraine

All patients with a confirmed diagnosis of migraine should be offered acute pharmacological and/or nonpharmacological treatment[1]

Nonpharmacologic interventions include counseling patients on the benefits of:

- Proper nutrition
- Regular exercise
- Adequate hydration
- Proper sleep
- Stress management
- Maintaining a migraine diary

Mild-to-moderate attacks → **NSAIDs, nonopioid analgesics, acetaminophen or caffeinated analgesic combinations**

Moderate-to-severe attacks OR **Mild-to-moderate attacks that respond poorly to nonspecific medications** → **Migraine-specific agents (triptans, ergotamine derivatives, gepants, ditans)**

Medication overuse headache[2]:

- Headache on **≥15 days/month** in a patient with a pre-existing primary headache due to **regular overuse**[a] of acute or symptomatic headache medication for >3 months
- Discontinuation of the overused medication(s) usually resolves medication overuse headache and improves responsiveness to preventive therapy

Criteria for initiating gepants, ditans or neuromodulatory devices for acute treatment[1]:

- Contraindication or inability to tolerate triptans **or**
- Inadequate response to ≥2 oral triptans

NSAID, nonsteroidal anti-inflammatory drug. [a]Defined as use of ergotamine derivatives, triptans, opioids or combination analgesics on ≥10 days/month for >3 months, or use of nonopioid analgesics, NSAIDs or simple analgesics on ≥15 days/month for >3 months.[2]

1. Ailani J, et al. Headache 2021;61:1021–39; 2. Headache Classification Committee of the International Headache Society. Cephalalgia 2018;38:1–211.

< Acute treatment goals

1. h
2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.

Diagnosis and treatment of migraine

2021 AHS Consensus Statement:

Goals of preventive migraine treatment

1. Reduce attack frequency, severity, duration, and disability
2. Improve function and reduce disability
3. Improve responsiveness to and avoid escalation in use of acute treatment
4. Improve health-related quality of life
5. Reduce reliance on unwanted, poorly tolerated or ineffective acute treatments
6. Optimize self-care and enhance sense of personal control
7. Reduce psychological symptoms and headache-related distress
8. Reduce overall treatment costs

AHS, American Headache Society.
The AHS Consensus Statement provides timely recommendations for clinicians and is not intended to be, and should not be understood or applied as, a clinical practice guideline.
Adapted from: Ailani J, et al. Headache 2021;61:1021–39.

Preventive treatments >

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2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.

Diagnosis and treatment of migraine

Preventive treatment of migraine

The AHS 2021 Consensus Statement recommends that preventive treatment should be considered for patients whose attacks significantly interfere with daily routines despite acute treatment; for those who have frequent attacks, intolerance or contraindication(s) to acute treatments, or failure or overuse of acute treatments; or based on patient preference[1a]

The AHS 2021 Consensus Statement[1] and the 2024 Updated Position Statement[2]

Use evidence-based treatments[1,2]

2024 Update: CGRP-targeting migraine therapies are a first-line option for migraine prevention. Initiation of these therapies should not require trial and failure of non-specific migraine preventive medication approaches.[2]

Classes of agents[b] with an FDA-approved indication for preventive treatment of migraine[c] include:

Oral treatments: anticonvulsants, beta-blockers, gepants

Intramuscular injection: neurotoxin

Subcutaneous injection: anti-CGRP monoclonal antibodies

Intravenous infusion: anti-CGRP monoclonal antibodies

Allow an adequate trial before switching[1]

Oral treatments:
≥8 weeks at target therapeutic dose or usual effective dose

Neurotoxin:
After ≥2 quarterly injections (6 months)

Anti-CGRP mAbs:
≥3 months (monthly administration) or ≥6 months (quarterly administration)

CGRP, calcitonin gene-related peptide; HIT, Headache Impact Test; IV, intravenous; mAb, monoclonal antibody; MIDAS, Migraine Disability Assessment; MHD, monthly headache day; MMD, monthly migraine day.
[a]Overuse defined as use of ergotamine derivatives, triptans, opioids or combination analgesics on ≥10 days/month for >3 months, or use of nonopioid analgesics, nonsteroidal anti-inflammatory drugs or simple analgesics on ≥15 days/month for >3 months. "Frequent attacks" includes ≥3 monthly headache days with severe disability, ≥4 monthly headache days with some disability or ≥6 monthly headache days without disability; [b]Only specific medications within each class are recommended in the AHS 2021 Consensus Statement[1]; [c]The 2021 AHS Consensus Statement identifies additional agents with evidence of efficacy in migraine prevention which do not possess FDA approval for that use; see the Consensus Statement for the full list.[1]

1. Ailani J, et al. Headache 2021;61:1021–39; 2. Charles AC, et al. Headache 2024; 64:333-41.

< Preventive treatment goals

2. Eigenbrodt AK, et al. Nat Rev Neurol 2021;17:501–14; 3. Ailani J et al, Headache. 2021;61:1021–39.