MIGRAINE	
Overview	Classically unilateral, pulsating, with gradual onset, lasting 4-72 hours, associated with nausea, vomiting, photophobia, and phonophobia. May be preceded by a prodromal aura with sensory, motor, or language symptoms.
ABORTIVE	
Lifestyle/Conservative	Nonpharmacologic management includes patient education, bed rest in a dark room, removal of known triggers, cold pack, constant temporal artery pressure, hyperbaric oxygen
Pharmacotherapy (mild to moderate)	Acetaminophen 1000 mg (High evidence)
	NSAIDs, i.e. ibuprofen and naproxen (AAN Grade A, High evidence)
	Aspirin 900 mg plus metoclopramide 10 mg (Mod evidence)
	Excedrin Migraine, which contains acetaminophen, aspirin, and caffeine (AAN Grade A, Mod evidence)
	Midrin, which contains acetaminophen, isometheptene, dichloralphenazone (AAN Grade B)
	Prochlorperazine (Compazine) IV, IM, or rectally (AAN Grade B, Mod evidence)
	Metoclopramide (Reglan) (AAN Grade B, Mod evidence) // *Less effective than other antiemetics*
Pharmacotherapy (moderate to severe)	Triptans available oral, intranasal and subcutaneous (AAN Grade A, Mod evidence)
	Dihydroergotamine (DHE) available subcutaneous, IV, IM, nasal (intranasal - AAN Grade A)
	Sumatriptan subcutaneous or intranasal provides faster relief but associated with more recurrent headaches compared to dihydroergotamine (Mod evidence)
	Intranasal lidocaine (Mod evidence)
	Butorphanol nasal spray, droperidol and haloperidol effective (Mod evidence) // *Limited due to side effects*
	Meperidine or other opioids (Mod evidence) - N*ot recommended; similar or better relief obtained with NSAIDs, dihydroergotamine, metoclopramide*
PROPHYLACTIC	*Consider initiating treatment when quality of life impaired, frequency of attacks > 1 per month, migraine attacks do not respond to acute drug treatment, or frequent, very long or uncomfortable auras*
Lifestyle/Conservative	Identify and avoid food triggers, improve sleep hygiene (Low evidence)
	Aerobic exercise, yoga may help (Mod evidence)
Alternative Medicine	Acupuncture effective, but no better than sham, massage therapy (Mod evidence)
Psychological	Mind-body therapies including CBT, biofeedback, guided imagery, "headache school" (Mod evidence)
Supplements	Butterbur extract (75 mg BID) (AAN Level A, Mod evidence)
	Others including riboflavin, magnesium, CoQ10, feverfew
Pharmacological	Beta blockers, i.e. propranolol 80-160 mg/day or metoprolol 100-200 mg/day (AAN Level A, Mod evidence)
	TCA, i.e. amitriptyline 10-100 mg/day (AAN Level B, Mod evidence)
	Topiramate, i.e. topiramate 50 mg BID(AAN Level A, Mod evidence)
	Botulinumm toxin
	Other therapies include antiepilepitcs (divalproex, gabapentin), antidepressants (venlafaxine, pizotifen), anti-hypertensives (nadolol, lisinopril, candesartan, and flunarazine)
	Daily opioid maintenance - Not recommended due to possible adverse events including daily rebound between doses
KEY	Benefits clearly outweigh the harms with sufficient evidence, or possibility of benefit with minimal risk
	Benefits do not clearly outweigh the harms, or conflicting or limited evidence of efficacy
	Benefits do not outweigh the harms, evidence suggests poorer outcomes

Information was gathered from Dynamed accessed via Tufts

AAN = American Academy of Neurology