

AAN/AHS Update Recommendations for Migraine Prevention in Adults

Guideline source: American Academy of Neurology, American Headache Society

Evidence rating system used? Yes

Literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? No

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Available at: <http://www.neurology.org/content/78/17/1337.full> and <http://www.neurology.org/content/78/17/1346.full>

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Studies suggest that more than one-third of persons with migraine need preventive therapy; however, only 3 to 13 percent use it. The American Academy of Neurology (AAN) and American Headache Society (AHS) recently reviewed studies published since 2000 to determine which therapies reduce migraine frequency or severity, or reduce the number of days with migraine. These guidelines do not address onabotulinumtoxinA (Botox), which the AAN described in 2008 as probably ineffective for the treatment of episodic migraine.

Pharmacologic Therapies

Evidence to support pharmacologic treatment strategies for migraine prevention indicates which treatments might be effective, but is insufficient to establish an optimal therapy. Therefore, treatment regimens need to be individualized based on the effectiveness and adverse effects of medications, comorbid conditions, and personal considerations.

EFFECTIVE

Divalproex (Depakote), metoprolol, propranolol, timolol, topiramate (Topamax), and valproate (Depacon) are effective and should be offered for migraine prevention. Frovatriptan (Frova) should be offered for short-term prevention of menstrual-associated migraine.

PROBABLY EFFECTIVE

Amitriptyline, atenolol (Tenormin), nadolol (Corgard), and venlafaxine (Effexor) are probably effective and should be considered for migraine prevention. Zolmitriptan (Zomig) and naratriptan (Amerge) should be considered for short-term prevention of menstrual-associated migraine.

POSSIBLY EFFECTIVE

Candesartan (Atacand), carbamazepine (Tegretol), clonidine (Catapres), guanfacine (Tenex), lisinopril (Zestril), nebivolol (Bystolic), and pindolol may be considered for migraine prevention.

INADEQUATE OR CONFLICTING DATA ON EFFECTIVENESS

There is insufficient or conflicting evidence on the effectiveness of the following drugs for migraine prevention: acenocoumarol (not available in the United States), acetazolamide, bisoprolol (Zebeta), cyclandelate (not available in the United States), fluoxetine (Prozac), fluvoxamine, gabapentin (Neurontin), nicardipine (Cardene), nifedipine (Procardia), nimodipine (Nimotop), picotamide (not available in the United States), protriptyline, verapamil, and warfarin (Coumadin).

PROBABLY OR POSSIBLY INEFFECTIVE

Lamotrigine (Lamictal) is not effective for migraine prevention and should not be offered. Clomipramine (Anafranil) is probably ineffective and also should not be offered. The following drugs may also be ineffective for migraine prevention: acebutolol (Sectral), clonazepam (Klonopin), nabumetone, oxcarbazepine (Trileptal), and telmisartan (Micardis).

Nonsteroidal Anti-Inflammatory Drugs and Complementary Therapies

Studies suggest that some medications used for migraine may offer long-term protection against headache progression, whereas other agents may elevate progression risk. An epidemiologic study found that aspirin or ibuprofen may protect against progression from episodic to chronic headache conditions. However, studies assessing the efficacy of nonsteroidal anti-inflammatory drugs

and complementary treatments for migraine prevention are limited and should be considered relative to other available pharmacologic therapies.

EFFECTIVE

Petasites, a purified extract from the butterbur plant, is effective in reducing the frequency of migraine attacks, and should be offered for prevention.

PROBABLY EFFECTIVE

Fenoprofen, histamine, ibuprofen, ketoprofen, magnesium supplements, MIG-99 (extract of feverfew), naproxen (Naprosyn), naproxen sodium (Anaprox), and riboflavin supplements are probably effective and should be considered for migraine prevention.

POSSIBLY EFFECTIVE

Coenzyme Q10 supplements, cyproheptadine, estrogen therapy, flurbiprofen, and mefenamic acid (Ponstel) may be considered for migraine prevention.

INADEQUATE OR CONFLICTING DATA ON EFFECTIVENESS

There is insufficient or conflicting evidence on the effectiveness of the following therapies for migraine prevention: aspirin, hyperbaric oxygen, indomethacin (Indocin), and omega-3 supplements.

PROBABLY OR POSSIBLY INEFFECTIVE

Montelukast (Singulair) is not effective in reducing the incidence, frequency, or severity of migraines, and should not be offered.

CARRIE ARMSTRONG, *AFP* Senior Associate Editor ■

Answers to This Issue's CME Quiz

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|-----------------------|-----------------|-----------------------|
| Q1. D | Q4. B | Q7. A, D |
| Q2. A, B, C, D | Q5. C | Q8. A, B, C, D |
| Q3. D | Q6. A, B | |