

Case Studies in Headache

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Disclosure

Consultant: AbbVie; Amneal; Axsome; Bausch Health;
Eli Lilly; Ipsen; Pfizer

Research Grant (Paid to Institution): ShiraTronics



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Learning Objectives

- Discuss individualized treatment approaches for migraine
- Incorporate newer treatments into practice
- Describe rational polypharmacy in complex headache care
- Incorporate advanced communication strategies in clinical encounters

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26-Year-Old Woman with Migraine

- Frequency varies from 2-6 HA days/month
- Significantly impaired from attacks up to 2 days per month
- Works as a criminal trial lawyer, on track to partnership
- Enjoys training for and competing in amateur triathlons
- Recently married and would like to start trying to get pregnant in about 6 months
- Has only ever used non-prescription analgesics for migraine
- Asking for advice on acute treatment and migraine prevention

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CLINICAL GUIDELINE

Pharmacologic Treatments of Acute Episodic Migraine Headache in Outpatient Settings: A Clinical Guideline From the American College of Physicians

Amir Qaseem, MD, PhD, MHA; Jeffrey A. Tice, MD; Itziar Etxeandia-Ikobaltzeta, PharmD, PhD; Timothy J. Wilt, MD, MPH; Curtis S. Harrod, PhD, MPH; Thomas G. Cooney, MD; and Carolyn J. Crandall, MD, MS; for the Clinical Guidelines Committee of the American College of Physicians*

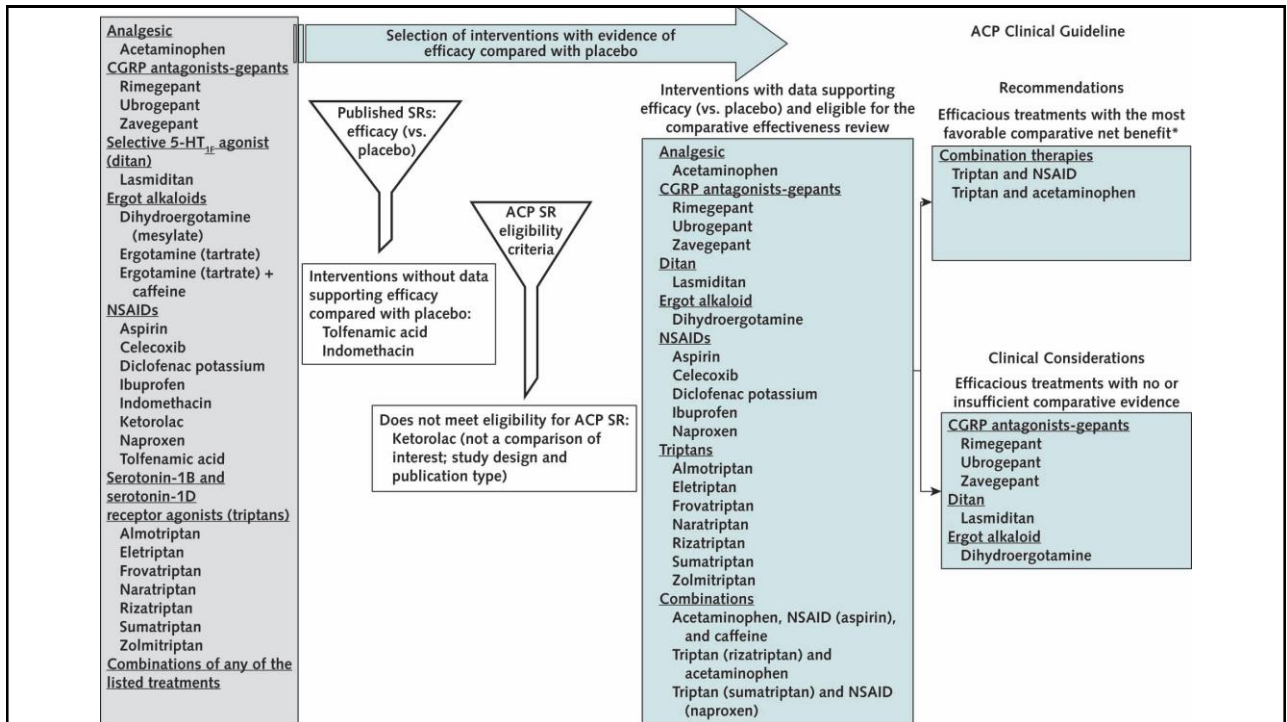
Qaseem A, et al. Ann Intern Med. 2025 Apr;178(4):571-578. doi: 10.7326/ANNALS-24-03095.

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Key Points

- Many options backed by efficacy data
- A handful of options also carry evidence of favorable comparative net benefit
- Main recommendations:
 - Add a triptan to acetaminophen or an NSAID when either alone is insufficient
 - Consider use of gepants, lasmiditan, and dihydroergotamine in select cases, acknowledging gaps in evidence as well as higher costs of these options

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Other Key Considerations

- When attacks are infrequent, treat at **THE FIRST SIGN** of an attack (prodrome or pain)
- Consider **non-oral** medications when nausea/vomiting problematic or for rapidly escalating attacks
- **Metoclopramide** can help both with nausea and gastric stasis during attacks, thus enhancing drug absorption
- Consider **gepants** and **lasmiditan** for patients with cardiovascular disease

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Remember the Quick Guides!



americanheadachesociety.org/resources/primary-care/migraine-quick-guides



Migraine Quick Guides

Explore key information on the diagnosis and management of migraine and other headache disorders including acute and preventive treatment, navigating work up, behavioral treatment, and more.

[Access Quick Guides →](#)



How Do I Discuss Behavioral Treatment With My Patient With Migraine?

[Download Now](#)



8 Things To Know About Migraine

[Download Now](#)



How Do I Help My Patient Choose The Right Acute Treatment?

[Download Now](#)

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**FEBRUARY
2026**

How Do I Help My Patient Choose the Right Acute Treatment?

Laura Xanders, FNP-BC and
Maureen Moriarty, DNP, APRN, FAHS, FAANP

Step 1: Collect Relevant History

What is their headache frequency?

- How many days do they have headache in a typical month and what proportion are severe?
- Consider the characteristics associated with attacks, such as whether they can tolerate oral medications.
- Are their headaches rapid or gradual in onset?

Step 2: Think About Comorbidities and Contraindications

Clarify whether any comorbid conditions or contraindications exist.

- Oral NSAIDs are generally contraindicated in patients with a history of stomach ulcers.
- Triptans are generally contraindicated in patients with cardiovascular disease or uncontrolled hypertension.
- Pregnancy/lactation status could impact safe

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Triptan Comparison

Versus Sumatriptan 100 mg	Initial 2h Relief	Sustained Pain-free	Consistency (2/3 attacks)	Tolerability (vs placebo)
Sumatriptan (50 mg)	=	=	=/-	=
Zolmitriptan (2.5 mg)	=	=	=	=
Naratriptan (2.5 mg)	-	-	-	++
Rizatriptan (10 mg)	+	+	++	=
Eletriptan (80 mg)	+(+)	+	=	-
Almotriptan (12.5 mg)	=	+	+	++

- inferior, =/- possibly inferior, = no difference, + better, +(+) possibly much better, ++ much better compared to 100 mg sumatriptan

Ferrari MD et al. Lancet 2001;358:1668-1675

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Accepted: 29 July 2026

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SPECIAL ARTICLE



Pharmacologic Treatment for Migraine Prevention in Adults Practice Guideline Recommendations

Report of the AAN Guidelines Subcommittee and the American Headache Society

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Endorsed by:



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Key Points

- Recommend prevention when:
 - frequency is 6+/month
 - attacks are moderate/severe 4+ days/month
 - impairment is present 2+ days/month
- Agent selection hinges on efficacy, tolerability, safety, comorbidities, lifestyle, and cost
- Main recommendations:
 - Episodic migraine: atogepant, mAbs, propranolol, topiramate, valproate
 - Chronic migraine: same EXCEPT no propranolol and add onabotA

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CLINICAL CASE STUDY & GUIDELINE APPLICATION

AHS/AAN Evidence-Based Path

Navigating Migraine Prophylaxis in Complex Patient Lifestyles

 1. Profile & Eligibility

Demographics

28 y/o Female (Reproductive Age)

Profession

Trial Attorney (High Cognitive Load)

Lifestyle

Competitive Triathlete

AHS/AAN RECOMMENDATION 1 CRITERIA

 **6 Monthly Migraine Days (MMDs)**

Eligible for prophylaxis initiation (Threshold: ≥ 4 days/month with significant disability).

Image generated with GoogleAI

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 2. The Screening Filter

Traditional Oral Failures

Why standard legacy first-line oral drugs fail or are clinically inappropriate for this specific patient:

Topiramate

Contraindicated / Inappropriate

- Teratogenic risk / childbearing age
- Cognitive slowing / 'Dopamax' impact on legal work

Propranolol (Beta-Blocker)

Inappropriate

- Blunts HR response / exercise intolerance in athletes

Valproate / Divalproex

Teratogenic Alert

- Strictly contraindicated (high teratogenicity rate)

3 of 3 traditional classes filtered out

Image generated with GoogleAI

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3. Clinical Resolution

OPTIMAL GUIDELINE-SUPPORTED PATH

CGRP Pathway Targeted Therapies

Monoclonal antibodies (mAbs) or Gepants supply high-efficacy prophylaxis without cognitive fog, bradycardia, or teratogenic restrictions.

- **Cognitive Preserved:** Lawyer retains sharp acuity
- **VO: Max Maintained:** No beta-adrenergic blockage
- **Favorable Profile:** Clean relative safety windows

CONSENSUS RECOMMENDATION

Advance directly to targeted CGRP classes

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Which One Would You Pick?

- Erenumab
- Galcanezumab
- Fremanezumab
- Eptinezumab
- Rimegepant
- Atogepant

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Which One Would You Pick?

- Erenumab
- Galcanezumab
- Fremanezumab
- Eptinezumab
- **Rimegepant*+**
- **Atogepant+**

Rationale: Planning pregnancy in about 6 months, therefore, best to choose gepant with short half-life

* Rimegepant not explicitly named in topline CGRP-targeting preventive guideline recommendations

+ No gepants have been studied in pregnancy

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48-Year-Old Woman with Migraine with Aura

- Frequency varies from 2-4 HA days/month
- Completely disabled for 1-2 days at a time with most attacks
- Visual aura with about 75% of attacks, can be nearly blinding
- Uses rizatriptan 5 mg to treat attacks, waits until pain is moderate-to-severe (due to side effects from rizatriptan)
- Taking duloxetine 30 mg daily for dual purpose treatment of anxiety and migraine prevention
- Bothered by perimenopausal symptoms (insomnia, irritability, vasomotor) and interested in HRT

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48-Year-Old Woman with Migraine with Aura

- Frequency:
2-4/month
- Completely disabled:
avg 4 days/month
- Visual aura
- Acute:
rizatriptan 5 mg
- Preventive:
duloxetine 30 mg

Questions:

- 1. What to do to optimize acute treatment?**
- 2. Does she need better prevention?**
- 3. Are hormones safe?**

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48-Year-Old Woman with Migraine with Aura

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48-Year-Old Woman with Migraine with Aura

Questions:

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Migraine Treatment Optimization Quiz

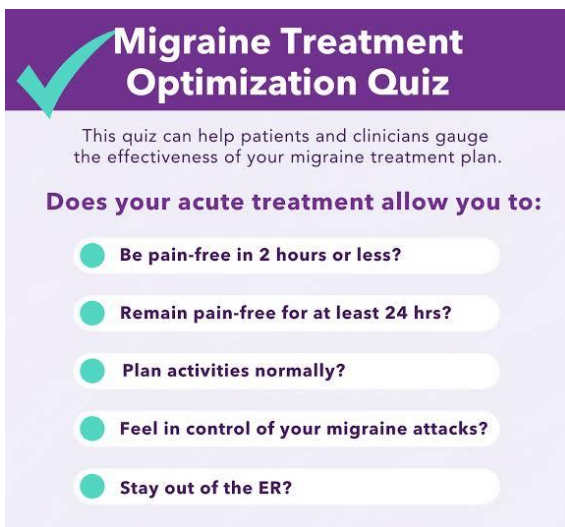
This quiz can help patients and clinicians gauge the effectiveness of your migraine treatment plan.

Does your acute treatment allow you to:

- ☐ Be pain-free in 2 hours or less?
- ☐ Remain pain-free for at least 24 hrs?
- ☐ Plan activities normally?
- ☐ Feel in control of your migraine attacks?
- ☐ Stay out of the ER?

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mTOQ



Migraine Treatment Optimization Quiz

This quiz can help patients and clinicians gauge the effectiveness of your migraine treatment plan.

Does your acute treatment allow you to:

- ☐ Be pain-free in 2 hours or less?
- ☐ Remain pain-free for at least 24 hrs?
- ☐ Plan activities normally?
- ☐ Feel in control of your migraine attacks?
- ☐ Stay out of the ER?

- There are a few versions, 4-6 questions, yes/no vs frequency scale (never, less than half the time, etc)
- Two versions also ask about quick return to normal function and tolerability
- Do not assess HOW acute medication is used

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48-Year-Old Woman with Migraine with Aura

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48-Year-Old Woman with Migraine with Aura

Questions:

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48-Year-Old Woman with Migraine with Aura

Acute Ideas

- Treat early
- Gentler triptan (almo-, nara-)
- Gepant
- Combination approach
- Device: sTMS could be ideal (also dual for preventive)

Preventive Ideas

- Gepant or mAb
- Lamotrigine (good for aura)
- Candesartan (well-tolerated)
- Venlafaxine (replace duloxetine, help with perimenopause)

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The Four Columns: Mix and Match

Serotonergic	Anti-CGRP	Analgesic	Dopaminergic
Ergotamine	Ubrogepant	Acetaminophen*	Metoclopramide
<i>oral, rectal</i>	Rimegepant	Ibuprofen	Prochlorperazine
Dihydroergotamine	Zavegepant	Naproxen	Promethazine
<i>intramuscular, intranasal</i>		Diclofenac	Olanzapine
Triptans	<i>More to come?</i>	Indomethacin	Haloperidol
<i>multiple routes</i>		Ketorolac (COX-1)	Chlorpromazine
Lasmiditan ⁺		Celecoxib (COX-2)	<i>Listed roughly order</i>
		Steroid	<i>of tolerability</i>

Pick one from each column and take as combination
 BID/TID 3-10 days (within safe dosing)

+ Lasmiditan not currently manufactured

*Acetaminophen can be combined with any of these as well

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NSAIDs: Beyond Ibuprofen and Naproxen

- Piroxicam, nabumetone, and oxaprozin – longer half-life, could be useful for pre-emptive treatment or for long-duration attacks
- Mefenamic acid – unique chemistry, some evidence in menstrual migraine
- Aspirin – when's the last time you suggested it?
- And never forget one of my favorite medications of all time..... indomethacin!

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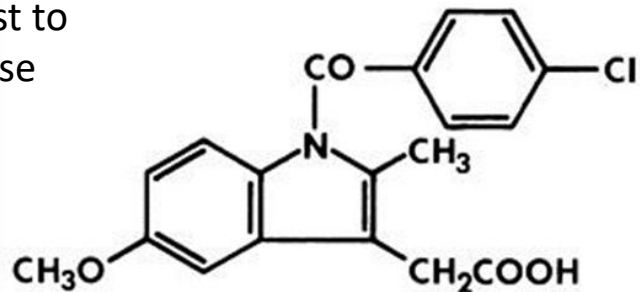
Indomethacin Responsive Syndromes

- Paroxysmal hemicrania
 - Hemicrania continua
 - Cough headache
 - Primary headache associated with sexual activity
 - Primary exercise headache
 - Primary stabbing headache
 - Migraine
 - Secondary and refractory headaches
- ← In ICHD-3 criteria
- } The “traditional” syndromes
- Don't forget!

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Indomethacin

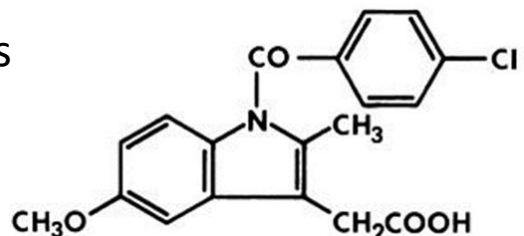
- Start 25 mg bid/tid and titrate rapidly to effect, no higher than 100 mg tid, but at least to 50 mg tid to ensure response
- Watch for AEs (GI, renal, cardiac)



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Indomethacin: Non-NSAID Properties

- Inhibits nitric oxide and secondarily cerebral blood flow (thus can also reduce intracranial pressure)
- Potentiates CB1 receptors
- Inhibits superior salivatory nucleus
- Can reduce uterine contractions
- Can close the patent ductus arteriosus



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Neuroleptics

More
Effective



Less
Effective

Drug	Typical dose	Disadvantages	Advantages
Haloperidol	2-5 mg po/IM	Akathisia Long ½ life	Very effective
Chlorpromazine	10-25 mg po, repeat hourly prn	Sedation Hypotension	Calming for crisis
Olanzapine	2.5-10 mg po, repeat prn (max 20 mg)	Sedation, food cravings	Calming for crisis
Prochlorperazine	10 mg po/PR/IM	Dystonic reactions	No QTc problem
Metoclopramide	10 mg po/IM	Akathisa	Not as sedating
Promethazine	12.5-25 mg po/PR	Sedation	Less EPS

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Medications and QTc Prolongation

Known Risk of TdP	Possible Risk of TdP	Unlikely or conditional risk	No known risk
Chlorpromazine Droperidol Haloperidol Domperidone Hydroxychloroquine Citalopram Escitalopram Ondansetron Methadone Cocaine	Aripiprazole Lithium Tizanidine Venlafaxine Promethazine Nortriptyline Des/(tr)im/ipramine Lurasidone Oxytocin Buprenorphine, Hydrocodone, Tramadol Levetiracetam	Ami/pro/triptyline Clomipramine, Doxepin Fluoxetine, Paroxetine, Sertraline Amantadine Metoclopramide Olanzapine, Risperidone, Quetiapine, Ziprasidone Furosemide, HCTZ Hydroxyzine Pantiprazole	Duloxetine (Levo)milnacipran Vortioxetine Prochlorperazine Trimethobenzamide

Information from: www.crediblemeds.org (or torasdes.org – easier to remember)

There's also an app! **CredibleMeds**

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48-Year-Old Woman with Migraine with Aura

Questions:

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2. Does she need better prevention?
3. Are hormones safe?

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48-Year-Old Woman with Migraine with Aura

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Perimenopause and Migraine with Aura

All about that dose

- Estrogen (and aura) dose drives risk
- Modern doses much lower
- Estradiol/esterol preferred over ethinylestradiol
- Progestogen-only is an option
- Continuous regimen avoids peaks/valleys

Don't forget non-HRT

- SNRI/SSRIs
 - Venlafaxine
 - Escitalopram
- Lifestyle
 - Nutrition
 - Optimize exercise AND sleep
 - Stress management
 - Social engagement

Kamourieh S, MacGregor EA. Climacteric. 2026 Aug;29(4):507-515. doi: 10.1080/13697137.2026.2675559.

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62-Year-Old Man with Migraine

- Frequency varies from 4-10 HA days/month
- Significantly impaired from attacks about 2 days per month
- Has been told not to use triptans since MI age 58
- Treated for HTN, HLD, DM II (all stable)
- Prior preventive treatment failures:
 - Topiramate (initially effective, then lost effectiveness)
 - Propranolol (not tolerated, fatigue & hypotension)
 - Amitriptyline (not tolerated, constipation & weight gain)

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62-Year-Old Man with Migraine

Acute Ideas

- Fast-acting NSAID (injection, nasal, oral solution)
- Gepant or lasmiditan
- Combination approach
- Device: any

Preventive Ideas

- Candesartan (already treated for HTN, so need to consider that)
- Simvastatin + vitamin D
- Gepant or mAb
- Device: any

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47-Year-Old Woman with Migraine

- Frequency has been stable at 1-3 HA days/month until recently
- Change in work schedule/demands, increased stress in personal life, frequency rising to 6-10 HA days/month
- In past, chronic migraine with medication overuse headache
- Afraid of overusing or running out of her acute medication (rimegepant)
- Prior preventive treatment failures:
 - Topiramate (initially effective, then lost effectiveness)
 - Propranolol (not tolerated, fatigue & hypotension)
 - Amitriptyline (HELPED but not tolerated, constipation & weight gain)

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47-Year-Old Woman with Migraine

Acute Ideas

- Re-introduce any non-gepant
- Lasmiditan
- Combination approach
- Device: any

Preventive Ideas

- Rimegepant or atogepant
- mAb
- Venlafaxine
- Device: any

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Meet Jared



- Jared is 38 with continuous headache, 7-10/10 every day, lots of nausea, waxing and waning daily vestibular symptoms
- Preventive: onabotulinumtoxinA 200 units every 10 weeks, gabapentin 3600 mg/day (also for diabetic neuropathy), lisinopril 20 mg/day (also for hypertension), sertraline 200 mg/day (also for depression/anxiety), hydromorphone 2 mg QID
- Acute: eletriptan 18 tabs/month, butalbital-acetaminophen-caffeine 4-6 tabs/day, ASA-acetaminophen-caffeine 6-8 tabs day, extra hydromorphone
- Drinks 48 ounces of strong coffee to keep awake during day
- Clonazepam 3 mg to go to sleep at night
- Unable to work, unable to exercise, is obese
- Remains depressed and anxious despite “talk therapy” twice/week

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Getting Back on Track

- Address likely rebound
- Address comorbidities
- Consider changing preventive medications
 - Find minimum effective doses (which may lead to discontinuing one or more)
 - Look for opportunities (eg, candesartan for HTN or duloxetine for anxiety, depression, and painful diabetic neuropathy)
 - Try preventives that are “outside the box”
- **REFER TO A SPECIALIST FOR COMANAGEMENT!**

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Minocycline

- Typical dose 100 mg BID, no titration needed
- Good for acne and rosacea
- Potential AEs: UTI, yeast infection, intracranial hypertension, photosensitivity, discoloration of skin and other tissues
- Purported mechanism: reduces inflammatory activity of glial cells

Hazey MA, et al. W V Med J 2009;105(1):15-17.
Fried NT, et al. Cephalalgia 2018;38(4):674-689.

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Memantine

- Start 5 mg QHS and increase weekly to 10 mg bid
- Can also use XR formulation (7 mg/day → 28 mg/day)
- Does not seem to help improve cognitive problems related to pain, mood, or meds
- Potential AEs: dizziness, GI effects, insomnia, headache

Mondia MWL, et al. Acta Med Philippina 2022;56(8):58-67.

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Mexiletine

- No IV lidocaine trial required
- Start 150 mg daily/bid, titrate as tolerated up and up
- Check peak levels starting at 450 mg/day
- Once into therapeutic range, increase gradually as levels may rise unpredictably
- Also comes in 200 mg and 250 mg
- Follow EKG and LFT
- Common AEs: nausea, blurry vision, tremor

Marmura MJ, et al. Headache 2008;48(10):1506-1510.

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Methylergonovine

- Start 0.2 mg bid/tid and can increase to 0.4 mg tid
- Drug holiday every 6 months vs monitoring with CT C/A/P and cardiac echo (controversial)
- Not ideal for patients on triptans, but can do with caution (be gentle to your pharmacist)
- May potentiate DHE effect (could be good or bad)
- Potential AEs: nausea, vasoconstrictive effects (eg, HTN, angina, other ischemia)

Saper JR, Evans RW. Headache 2013;53(2):378-381.

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Other Pearls

- Add a little TCA to an SSRI to mimic the effect of an SNRI
- Gabapentin is sometimes helpful acutely, alone or on top of baseline gabapentin prophylaxis, with no rebound potential
- Pregabalin is more effective than gabapentin for some patients, with simpler dosing (but is a controlled substance)
- Refractory migraine with aura: think lamotrigine, sTMS
- Tough “dizzy” migraine: think lamotrigine, citalopram, eTNS, nVNS
- Hypertension (or at least no hypotension): I like metoprolol and candesartan

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Does This Scenario Sound Familiar?

- Ms. S is 68, socially isolated, widowed, with refractory chronic migraine and multiple other somatic complaints; started seeing you 15 months ago
- Always asking for more tests to find out what's wrong despite multiple unremarkable diagnostics over the last decade
- "My last doctor, one of the best in the world, always ordered tests on me. Why don't you?"
- Consistently demands more than the 20 minutes allotted for appointments with last minute "oh by the way" complaints
- Always seems to have excuses for not following your recommendations

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Core Principles for Handling Frustrating Cases

- The clinician-patient relationship should be the target for change
- The patient's emotional experience should be an explicit focus of the clinical interaction
- The patient's perspective should guide the clinical encounter



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Approaches to Difficult Encounters

Make your relationship, not the "disease," the target of change

Communication Technique: Elicit emotions via direct and indirect questioning

Ask directly:

"How does that make you feel?"

Assess life impact:

"With so many days with headache, I'm wondering how you are handling things."

Get the patient's perspective:

"Do you have any thoughts on what's behind your headaches?"

Self-disclose:

"My mother struggled with chronic migraine for years, too, but she stuck with it and finally found the right treatment."

Visit Structure:

Schedule frequent, regular, brief appointments in advance



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Approaches to Difficult Encounters

Focus the discussion on your patient's emotional experience

Communication Technique: Offer support and empathy

Name the affect:

"You sound sad."

Validate:

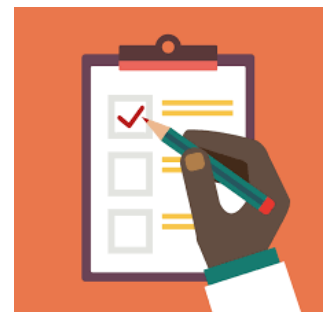
"You've lost your husband, and you have pain all over your body. That's a lot for anyone to cope with."

Align:

"I want to do everything in my power to get your pain under control so you can get back to enjoying life."

Visit Structure:

Set the agenda at the beginning of each appointment



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Approaches to Difficult Encounters

Allow the patient's perspective to guide the clinical encounter

Communication Technique: Use nonverbal behaviors that convey attentive listening

- Thoughtful nodding
- Allow for space with occasional silence
- Lean towards the patient
- Use open postures and gestures
- Use compassionate touch when appropriate
- Keep your eyes on the patient, not on the clock



Visit Structure:

- De-emphasize diagnostic tests, prescriptions, and other passive treatments
- Explore personal stressors, concerns, values, successes, rewards

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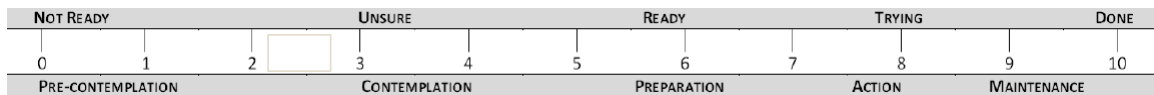
“People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others.”

Blaise Pascal

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Basic Principles of Motivational Interviewing

Readiness Ruler



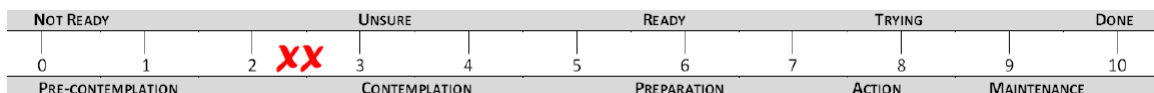
Ask:

- Can we talk more about making a change?
- How ready do you think you are to make that change?

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Basic Principles of Motivational Interviewing

Readiness Ruler



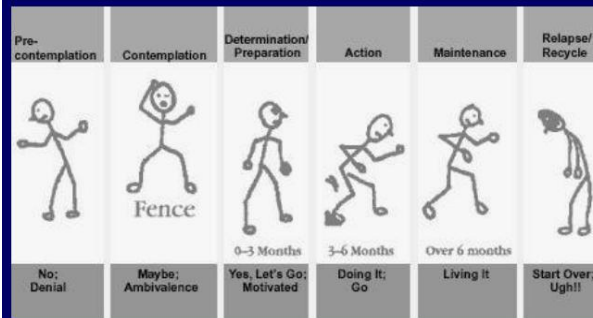
Follow up with:

- Why didn't you mark lower on the ruler, closer to a 1?
- What would it take to raise that number?
- What are the pros and cons of making a change or doing nothing?

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Basic Principles of Motivational Interviewing

Stages of Change: Prochaska



Four Steps of MI

1. Engage in sensitive conversations with the patient.
2. Focus on what is important to the patient regarding behavior, health, and welfare.
3. Evoke the patient's personal motivation for change.
4. Negotiate plans.

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When Things Go Right in Refractory Migraine



- View patients with CM/MOH as people with episodic migraine waiting to be set free
- Serious CM/MOH can be managed as an outpatient, but may require infusion/hospitalization
- Many strategies available to achieve success

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Summary

- Two important presentations requiring special attention are **status migrainous** and **refractory migraine**
- **Antagonizing CGRP** and **agonizing 5-HT_{1F}** currently the most targeted approaches to migraine
- **Devices** are gaining popularity
- Sometimes, **effective communication** is your best tool
- New treatments are here and on the way – **get to know them!**
- There remains much to be discovered – **get in the game!**

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Online Resource Library

First Contact – Headache in Primary Care provides free educational resources to help you identify and treat migraine and other headache disorders.



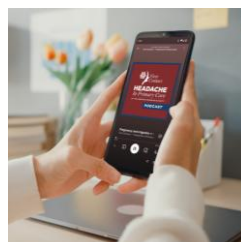
Migraine Management
Flowchart



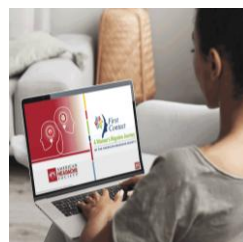
Quick Guides



Patient Guide Library



Official Podcast



Online First Contact
Presentations

americanheadachesociety.org/resources/primary-care

Learn more and explore
our resources here:



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