About the Guideline

- The guideline was created by a work group that consisted of experts from both the Department of Veterans Affairs (VA) and the Department of Defense (DoD), together with outside experts, who did a systemic review of clinical studies between January 1, 2009, and March 6, 2019.
- The work group also solicited input from a patient focus group whose members experienced headaches for more than 10 years and who ranged in age between 40 and 60 years old.
- The ambulatory setting is the primary emphasis of this guideline's recommendations and thus it does not thoroughly address emergency management of headaches. However, intravenous treatments are considered and may be offered in the emergency room or infusion centers.
- The purpose of the guideline is to support primary health care providers in the management and prevention of headache in patients ages 18 and older through accurate assessment and treatment.
- The guideline should not be considered a standard of care and the only treatment method. Each patient's input through shared decision-making, along with consideration of each patient's individual needs and resources, should assist in determining the course of treatment.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline if you work in an acute care or ambulatory care setting.

Headache Classifications

- Primary headache disorders
  - Primary headaches occur spontaneously with an unknown cause, are stereotypical, and may recur.
  - Examples include migraine, cluster type headache, and tension-type headache.
- Secondary headache disorders
  - Secondary headache presents as a new onset and parallel to an illness that is known to cause headaches.
  - Examples include head and/or neck trauma; a cranial or cervical vascular disorder; a nonvascular intracranial disorder; substance use and/or withdrawal; infection; homeostasis illness; illness of the cranium, neck, eyes, ears, nose, sinuses, mouth, or other facial or cervical structure; or a psychiatric disorder.
- Assessment should be made to determine whether the patient is experiencing a primary headache versus a secondary headache.
  - Consider duration and frequency; characteristics such as severity, location, quality, and what activities exacerbate it; features such as light sensitivity or noise aggravating the headache; and nausea and vomiting or autonomic dysfunction.
- The guiding principle in assessing for secondary headache is determining if there is a parallel cause that can be associated with headache onset. Resolution of the parallel disorder may in turn resolve the headache.
Screening and Healthcare Settings

- Assess patients with headache for medication overuse headache (MOH). The following are indicators:
  - Recurrent use of analgesics, anxiolytics, or sedatives
  - Inactivity
  - History of whiplash as reported by the patient
  - Depression or anxiety, without gastrointestinal or musculoskeletal ailments
  - Absenteeism from work for more than two weeks in the last year
  - Smoking
- There is no recommendation for or against a specific medication withdrawal treatment or strategy.

Nonpharmacologic Therapy

- For tension-type headache management, physical therapy is suggested.
- For headache management, the following are suggested:
  - Progressive strength training or aerobic exercise (unless aggravating factors prevent exercise)
  - Mindfulness-based therapy
- To prevent migraines, education regarding avoidance of dietary triggers is suggested.
- Treatment of episodic cluster headaches with noninvasive vagus nerve stimulation is suggested.
- There is no recommendation for or against treating headaches with any of the following:
  - Acupuncture
  - Dry needling
  - Pulsed radiofrequency or sphenopalatine ganglion block
  - Cognitive behavioral therapy or biofeedback
  - Immunoglobulin G antibody test-based elimination diet
  - Transcranial magnetic stimulation
  - Transcranial direct current stimulation
  - External trigeminal nerve stimulation
  - Supraorbital electrical stimulation

Pharmacotherapy

Migraine

- Preventative
  - Candesartan or telmisartan is recommended for episodic or chronic migraine.
  - Erenumab, fremanezumab, or galcanezumab is suggested for episodic or chronic migraine.
  - Lisinopril is suggested for episodic migraine.
  - Oral magnesium is suggested (nonspecific to the type of migraine).
  - Topiramate is suggested for episodic migraine.
  - Propranolol is suggested (nonspecific to the type of migraine).
  - OnabotulinumtoxinA injection is suggested for chronic migraine.
OnabotulinumtoxinA or abobotulinumtoxinA is not suggested for episodic migraines.

There is no recommendation either for or against the following:
- Episodic migraine prevention with niMODipine or NIFEdipine
- Migraine prevention with coenzyme Q10, feverfew, melatonin, omega-3, vitamin B2, or vitamin B6
- Migraine prevention by combination pharmacotherapy

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**Abortive**

- For acute treatment, solmitriptan (oral or intranasal), SUMAtriptan (oral or subcutaneous), or the combination of SUMAtriptan and naproxen is recommended.
- The following acute therapies are suggested:
  - Frovatriptan or rizatriptan
  - Triptans as an alternative to opioids and nonopioid pain relievers to avoid MOH
  - Ibuprofen, aspirin, acetaminophen, and naproxen
  - Greater occipital nerve block
  - Intravenous magnesium

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**Tension-Type Headache**

- **Preventative**
  - Amitriptyline for chronic tension-type headaches is suggested.
  - Botulinum/neurotoxin injection is not suggested for chronic tension-type headaches.
- **Abortive**
  - Ibuprofen 400 mg or acetaminophen 1000 mg is suggested as acute therapy.

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**Cluster Headache**

- **Preventative**
  - Galcanezumab is suggested for episodic cluster headaches.
- **Abortive**
  - There is no recommendation for or against any particular medication for acute treatment of cluster headaches.

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**Headache**

- **Preventative**
  - There is no recommendation for or against headache prevention with the following:
    - Oxygen therapy in primary headache
    - Valproate
    - FLUoxetine or venlafaxine
- **Abortive**
  - Intravenous ketamine is not suggested for acute treatment.
  - There is no recommendation for or against metoclopramide, intravenous prochlorperazine, or intranasal lidocaine for acute treatment.

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**Secondary Headache**

- **Abortive**
  - There is no recommendation for or against any certain medication therapy.
Reference:

Link to Practice Guideline:
https://www.healthquality.va.gov/guidelines/pain/headache/VADoDHeadacheCPGFinal508.pdf