Clinical Playbook

Optimizing Headache & Migraine Management at the Point of Care

A visual decision aid and rapid-recall framework
for diagnosis, triage, and therapeutics.

Triage SNOOP

PBS Therapeutics

MOH Mitigation

PREVALENCE

4.9 Million
Australians Affected

~15% women

~7% men

BURDEN

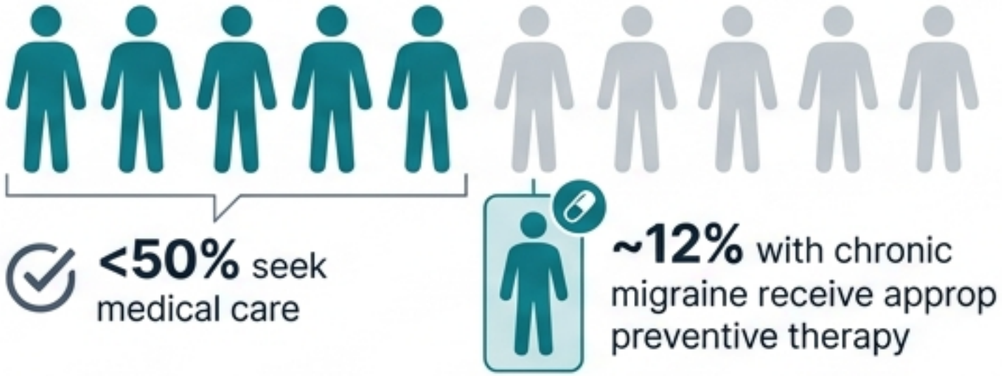
2nd Leading Cause of YLD

Years Lived with Disability globally, heavily impacting those aged 15–49.

ECONOMIC IMPACT

Exceeds $35 Billion
in annual direct and indirect costs in Australia.

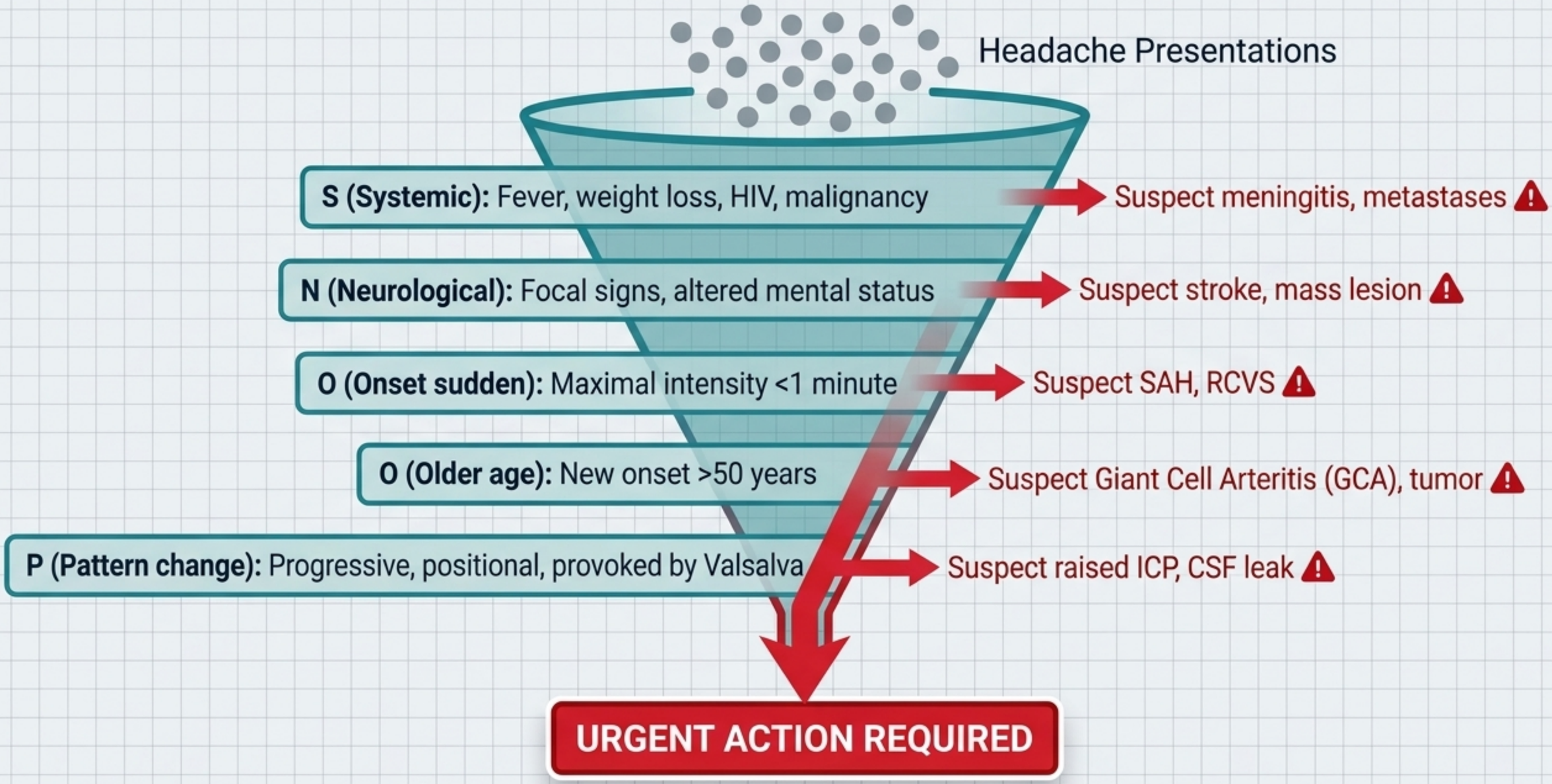
THE CARE GAP



<50% seek medical care

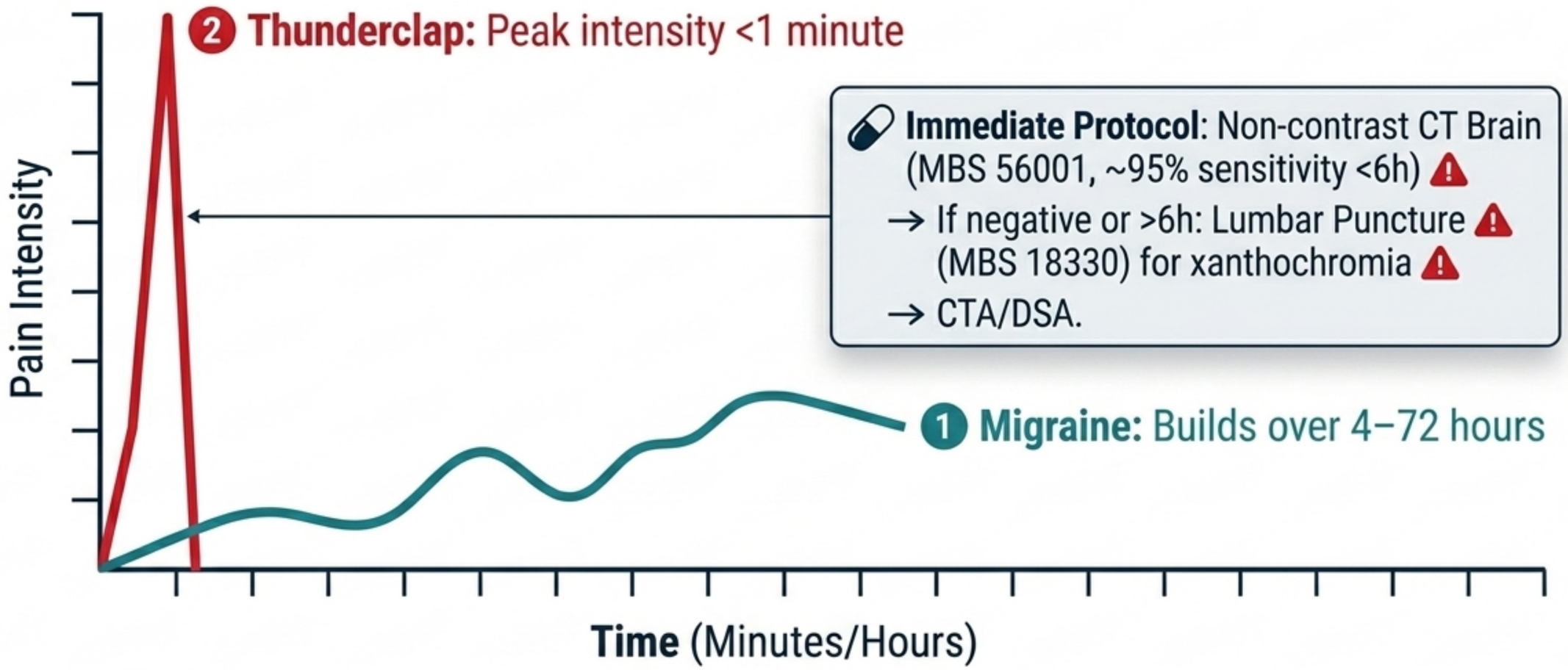
~12% with chronic migraine receive approp preventive therapy

Triage Filter Funnel



WARNING: Thunderclap is a medical emergency. Treat as code stroke equivalent.

The Thunderclap Profile



Urgency Triage Matrix

Clinical Scenario	Imaging Modality	Urgency
Thunderclap Headache or Suspected Meningitis	CT non-contrast → LP → CTA (For Thunderclap) | Blood cultures → Antibiotics → CT only if indicated before LP (For Meningitis)	**Immediate**
First severe headache with focal neurology or Suspected GCA	CT ± contrast or MRI (Focal) | Temporal artery US/biopsy, urgent ophthalmology, stat Prednisolone 1mg/kg/day (GCA)	**Urgent** (Same Day / 1 Hour)
New Daily Persistent Headache (NDPH)	MRI brain + contrast + MRV	**Within 2 Weeks**
Chronic migraine without red flags / typical pattern	Routine imaging NOT recommended	**Do Not Image**

Diagnostic Formula Checkbox Matrix

Migraine Without Aura Formula

- [ ] **[Duration:** 4–72 hours]

+

- [x] **[≥2 of:** Unilateral | Pulsating | Mod-Severe Pain | Aggravated by routine activity]

+

- [x] **[≥1 of:** Nausea/Vomiting | Photophobia + Phonophobia]

=

Migraine Without Aura
(Must have ≥5 attacks)

With Aura Panel

≥2 attacks featuring **fully reversible visual, sensory, speech, motor,** brainstem, or retinal symptoms spreading over ≥5 mins, lasting 5-60 mins, followed by headache <60 mins.

Action: Initiate preventive therapy.

Migraine Subtypes & Key Definitions

Episodic vs. Chronic

Episodic: <15 days/month. **Chronic:** ≥15 days/month for >3 months, ≥8 migraine days.

Chronic status unlocks PBS eligibility for CGRP mAbs & Botox.

Menstrual Migraine

Occurs Day -2 to +3 of menses.

Therapeutic Note: Frovatriptan 2.5mg BD prophylaxis from Day -2 to +4.

Hemiplegic Migraine

Aura with motor weakness. Genetic links (CACNA1A).

CONTRAINDICATION: TRIPTANS CI.

Basilar Migraine

Aura with ≥2 brainstem symptoms (vertigo, diplopia, ataxia).

CONTRAINDICATION: TRIPTANS CI.

Escalation Staircase

Triptan Contraindications:
Ischaemic heart disease, uncontrolled HTN, CVA/stroke history, Prinzmetal angina.

Step 1: Mild-Moderate

- **Simple Analgesics:** Aspirin soluble 900–1000mg PO **OR** Ibuprofen 400mg PO at onset.
- Avoid Aspirin in <16 years (Reye syndrome).

Step 2: Moderate-Severe

- **Triptans:** Sumatriptan 50–100mg PO (max 300mg/d) or 6mg SC.
- **Alternatives:** Rizatriptan 10mg PO, Eletriptan 40mg PO.

Step 3: Refractory Combo

- **Synergy Block:** Sumatriptan 85mg + Naproxen 500mg.
- Highest NNT (~2.2) for 2-hour pain freedom.

Triptan vs. Gepant/Ditan Matrix

Drug Class	Mechanism	Vasoconstriction?	Key Considerations	PBS Status
Triptans	$5\text{-HT}_{1B/1D}$ Agonists	⚠ YES	First-line specific agent.	General Benefit
Gepants (Rimegepant)	Oral CGRP Receptor Antagonist	✓ NO	Ideal for CV contraindicated patients. 75mg ODT.	Pending (TGA Approved)
Ditans (Lasmiditan)	Selective 5-HT_{1F} Agonist	✓ NO	Heavy CNS side effects (dizziness, no driving x 8h).	Pending (TGA Approved)

ED Protocol Timeline

1.

Metoclopramide 10–20mg IV (over 15 min) **+ IV Saline.** (Improves gastric stasis, watch for extrapyramidal effects).

2. Ketorolac 30mg IV (if no NSAID CI).

3. Dexamethasone 8mg IV. (Specifically reduces 72-hour recurrence).

4. Valproate 500–1000mg IV (over 30 min) for refractory cases.

5. Sumatriptan 6mg SC or 20mg Intranasal (if not yet trialed and no CI).

Preventive Therapeutics Matrix

Propranolol

- **Target:** 40-80mg BD.
- **Side Effects:** Hypotension, bradycardia.
- **CI:** Asthma.
- **Comorbidity Match:** High baseline HR, anxiety.

Topiramate

- **Target:** 50-100mg BD.
- **Side Effects:** Paraesthesiae, cognitive, nephrolithiasis.
- **Pregnancy:** Category D (Cleft palate).
- **Comorbidity Match:** Obesity (promotes weight loss).

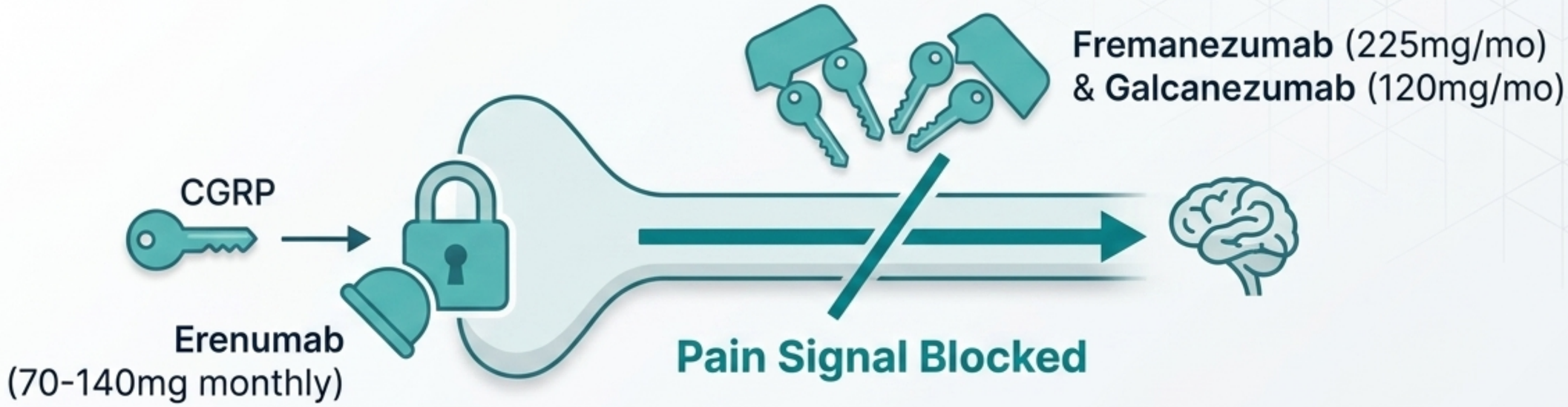
Amitriptyline

- **Target:** 25-75mg nocte.
- **Side Effects:** Sedation, anticholinergic.
- **Comorbidity Match:** Insomnia or neuropathic pain.

Sodium Valproate

- **Target:** 400-800mg/d.
- **Pregnancy:** Category D (Neural tube defects – highly restricted).
- **Monitoring:** FBC, LFTs.
- **Comorbidity Match:** Epilepsy.

CGRP Blockade Model



PBS Authority Required Criteria

- Diagnosis of Chronic Migraine (≥15 headache days, ≥8 migraine days) **AND** failure/intolerance of ≥2 oral preventives (minimum 8 weeks each).
- Must be endorsed by a Neurologist.

Note: OnabotulinumtoxinA (Botox) is an alternative under identical PBS rules (155-195 units, 31 sites).

The Vicious Cycle

Frequent Migraine / Tension Headaches

Escalating acute medication intake (seeking relief)

Overuse threshold crossed (>10-15 days/month for >3 months). CNS sensitization occurs.

Rebound headache develops. Baseline pain frequency increases.

Affects up to **50%** of patients in tertiary headache clinics.

MOH Risk Thermometer

Extreme Risk:
Triptans, Ergotamines, Opioids
Threshold: ≥10 days/month.
(Triptan MOH develops fastest, median 1.7 years)

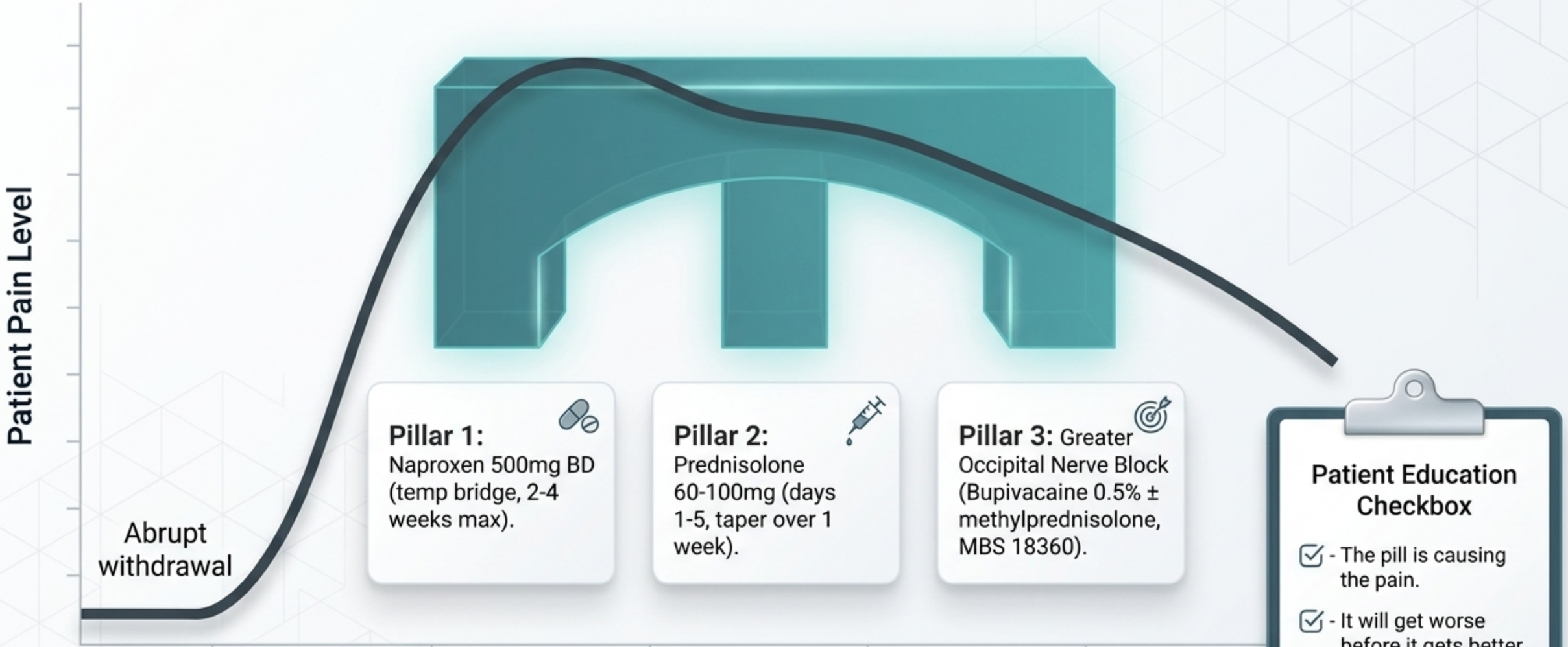
High Risk: Combination analgesics (Caffeine/Codeine)
Threshold: ≥10 days/month.

Moderate Risk: Simple Analgesics (Aspirin, Paracetamol, NSAIDs)
Threshold: ≥15 days/month.

Low Risk: Gepants
(Provisional threshold ≥18 days).

WARNING: Codeine-containing analgesics (prescription-only since 2018) remain a severe MOH driver in Australia; strictly screen for dependency.

The MOH Withdrawal Bridge



Pillar 1: Naproxen 500mg BD (temp bridge, 2-4 weeks max).

Pillar 2: Prednisolone 60-100mg (days 1-5, taper over 1 week).

Pillar 3: Greater Occipital Nerve Block (Bupivacaine 0.5% ± methylprednisolone, MBS 18360).

Patient Education Checkbox

- ☑ - The pill is causing the pain.
- ☑ - It will get worse before it gets better.
- ☑ - Initiate preventives simultaneously.

Pregnancy

Paracetamol is safest acute.

- Sumatriptan is Cat B1 (use if benefits outweigh risk, consider SC).
- Metoclopramide (Cat A) for nausea.
- Magnesium 400-600mg as prevention.

Warning Crimson

CONTRAINDICATED: Topiramate (Cat D), Valproate (Cat D), CGRP mAbs (washout 5 months prior).

Paediatrics

Paracetamol (15mg/kg) & Ibuprofen (10mg/kg) first-line acute.

- Sumatriptan nasal spray (12-17 years).
- Propranolol (1mg/kg/d) first-line prevention.

Warning Crimson

CONTRAINDICATED: Avoid Aspirin <16 yrs (Reye syndrome).

Elderly (≥65)

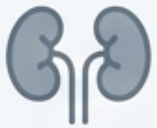
Paracetamol preferred (max 3g/day).

- New onset >50 requires imaging to exclude GCA.
- CGRP CGRPs are excellent due to lack of vasoconstriction.

Alert Amber

CAUTION: Amitriptyline (anticholinergic/falls) and Propranolol (bradycardia).

Medication Safety by Comorbidity



Renal Impairment

Safe to Use

- Paracetamol, CGRPs, Sumatriptan/Rizatriptan safe.

Contraindicated / Adjust

- **Adjust:** Topiramate (reduce 50% if eGFR <30).
- **Avoid:** NSAIDs in eGFR <30.

Hepatic Impairment

Safe to Use

- CGRPs safe (no hepatic metabolism).

Contraindicated / Adjust

- **Adjust:** Paracetamol (max 2g/d), Sumatriptan (reduce).
- **Avoid:** Sodium Valproate (Hepatotoxicity absolute CI).

Immunocompromised

Safe to Use

- CGRPs safe.

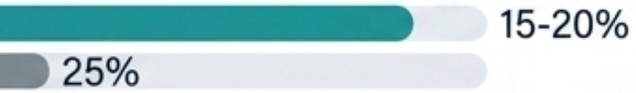
Contraindicated / Adjust

- **Adjust:** Corticosteroids (consult ID).
- **Action:** Low threshold for immediate CT/MRI + LP for any new/severe headache to exclude opportunistic infections or lymphoma.

The Disparity

Disparity

Prevalence in ATSI populations is 15-20%, yet <25% have a formal diagnosis.



Analgesic Overuse

Analgesic overuse is highly prevalent despite community store pack-size restrictions.

Comorbidity Burden

High burden of CV/renal comorbidities dramatically alters drug safety profiles.

The Geography Barrier

Pathway Note:

MRI is largely unavailable. Rely on regional **CT scanners** and **RFDS** aeromedical retrieval for thunderclap presentations.

Culturally Safe Care Checklist

Step 1

Communication

Integrate Aboriginal Health Workers for history-taking.

Recognize that severe headache may be misattributed (e.g., behavioral issues in children).

Step 2

Care Planning

Utilize MBS Item 721 (Chronic Disease Management Plan) to explicitly codify headache management alongside comorbid care.

Step 3

Accessing Therapeutics

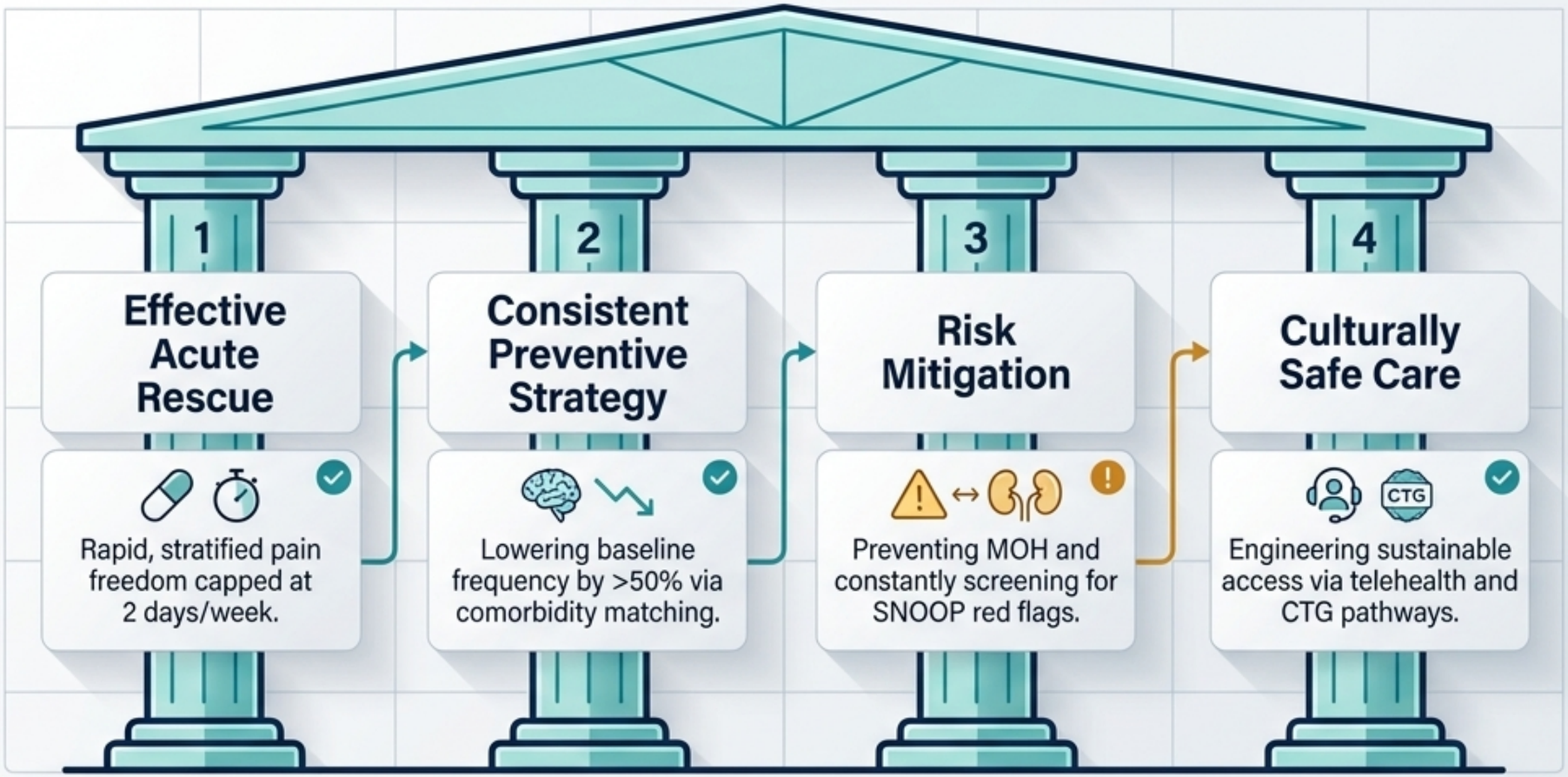
Utilize the Closing the Gap (CTG) PBS Co-Payment Program ($7.70 per script) to ensure affordability of preventives via ACCHOs.

Step

Specialist Interface

Maximize Telehealth Neurology (MBS 99200/99203) to bypass geographic barriers for CGRP/Botox authority approvals.

The Ecosystem of Migraine Management



Optimal care isn't just about prescribing the right molecule—it's about engineering a **sustainable, holistic** care system for the patient.