

photophobia at 2 hours (RR 1.19; 95% CI 0.90–1.58; 1 Class I study¹⁷).

Outcome: Relief of phonophobia at 30 minutes

Moderate confidence in the evidence

Adolescents receiving zolmitriptan NS 5 mg are probably more likely than those receiving placebo to be free of phonophobia at 30 minutes (RR 1.68; 95% CI 1.03–2.74; 1 Class II study⁸).

Outcome: Relief of phonophobia at 2 hours

Moderate confidence in the evidence

Adolescents receiving the following treatments are probably more likely than those receiving placebo to be free of phonophobia at 2 hours:

- Sumatriptan/naproxen OT 10/60 mg (RR 1.45; 95% CI 1.13–1.87; 1 Class I study¹⁷)
- Sumatriptan/naproxen OT 85/500 mg (RR 1.43; 95% CI 1.14–1.80; 1 Class I study¹⁷)

Children and adolescents receiving the rizatriptan ODT 5 or 10 mg are probably no more likely than those receiving placebo to be free of phonophobia at 2 hours (RR 1.07; 95% CI 0.97–1.18; 2 Class II studies^{10,11}).

Low confidence in the evidence

Adolescents receiving sumatriptan/naproxen OT 30/180 are possibly more likely than those receiving placebo to be free of phonophobia at 2 hours (RR 1.38; 95% CI 1.07–1.78; 1 Class I study¹⁷).

Adolescents receiving the following treatments are possibly more likely than those receiving placebo to be free of phonophobia at 2 hours:

- Sumatriptan NS 5 mg (RR 1.29; 95% CI 1.07–1.56; 1 Class II study⁶)
- Sumatriptan NS 20 mg (RR 1.34; 95% CI 1.11–1.62; 1 Class II study⁶)

Adolescents receiving eletriptan OT 40 mg are possibly no more likely than those receiving placebo to be free of phonophobia at 2 hours (RR 1.05; 95% CI 0.89–1.24; 1 Class II study¹⁶).

Very low confidence in the evidence

There is insufficient evidence to determine whether adolescents receiving the following treatments are more or less likely than those receiving placebo to have resolution of phonophobia at 2 hours:

- Sumatriptan NS 10 mg (RR 1.20; 95% CI 0.99–1.46; 1 Class II study⁶)
- Zolmitriptan NS 5 mg (RR 1.21; 95% CI 1.02–1.44; 1 Class I study¹⁵)

Practice recommendations

Establish a specific headache diagnosis

Recommendation 1 rationale

The appropriate care of a patient with headaches requires establishing a correct diagnosis. This affects our diagnostic approach, treatment, and prognosis. Patients with signs and symptoms of secondary headache, such as sudden change in headache, papilledema, focal deficits, and the additional presence of seizures, require further evaluation beyond a thorough history and physical examination. When migraine is diagnosed, tailored treatments may be considered that can result in improved outcomes.¹⁹ Diagnostic criteria for pediatric migraine include at least 5 headaches over the last year that last 2–72 hours when untreated, with 2 of 4 additional features (pulsatile quality, unilateral, worsening with activity or limiting activity, moderate to severe in intensity), and association with at least nausea, vomiting, photophobia, or phonophobia. These associated symptoms can be inferred by family report of the child's activities. The time a child sleeps can be considered part of the headache duration. Auras typically occur in about one third of older children and adolescents and precede the headache by 5–60 minutes.¹

Statement 1a

When evaluating children and adolescents with headache, clinicians should diagnose a specific headache type (primary, secondary, or other headache syndrome) (Level B).

Statement 1b

When evaluating children and adolescents with headache, clinicians should ask about premonitory and aura symptoms, headache semiology (onset, location, quality, severity, frequency, duration, and aggravating and alleviating factors), associated symptoms (nausea, vomiting, phonophobia, and photophobia), and pain-related disability in order to improve diagnostic accuracy for migraine and appropriately counsel the patient (Level B).

Acute migraine treatment

Recommendation 2 rationale

Migraine treatment should aim to achieve fast, complete pain relief, with minimum side effects. Associated symptoms like nausea, vomiting, photophobia, and phonophobia should also be addressed. In adults, early treatment of migraine (within less than 1 hour of headache onset) improves pain-free rates.²⁰ Improved efficacy with early treatment is likely to be seen in children and adolescents as well. Many children and adolescents use and benefit from nonprescription oral analgesics like acetaminophen, ibuprofen, and naproxen.²¹ Triptans are less commonly prescribed in children than in adults, and only almotriptan (for patients aged 12 years and older), rizatriptan (for patients aged 6–17 years), sumatriptan/naproxen (for patients aged 12 years and older), and zolmitriptan NS (for patients aged 12 years and older) are approved by the Food and Drug Administration (FDA) for use in children. Ergots and oral naproxen alone have not been studied in children.