The safety of triptans is well established, and the risk of de novo coronary vasospasm from triptan use is exceedingly rare. However, triptans are contraindicated in patients with known or suspected coronary artery or cerebrovascular disease because they might increase the risk of myocardial ischemia, infarction, or other cardiac or cerebrovascular events. Triptans should not be prescribed for patients taking ergot because of risk of synergistic effect causing vasospasm or in patients with hemiplegic or basilar migraine because of risk of vasospastic stroke (based on studies not included in the evidence base nor impacting the strength of the recommendation).(211, 212)

Information regarding the safety of triptans during pregnancy and breast feeding is limited, and non-pharmacologic treatment methods are emphasized in these situations. Emerging evidence (not included in the evidence base nor impacting the strength of the recommendation) suggests that if prescription abortive medication is considered necessary, triptans are as safe as, and more effective than, older agents, such as butalbital containing compounds, and can be considered in select cases under close observation.(213)

The Work Group considered the assessment of the evidence put forth in the 2020 Headache CPG because no new studies on this topic met inclusion criteria for the 2023 Headache CPG systematic evidence review.(204-209) Therefore, the recommendation is categorized as *Reviewed, New-replaced.* The Work Group's confidence in the quality of the evidence was moderate. The benefits outweighed the potential harm of AEs because reducing the pain was deemed worth experiencing mild and infrequent side effects. Patient preferences vary because not all patients tolerate needles. Small subgroups of patients are intolerant of triptans, experience hemiplegic migraine and cannot use these medications, or both. Subcutaneous medications are also more expensive than oral medications, though they are less expensive than newer migraine abortive medications or evaluation and treatment in the emergency department (ED) or inpatient settings. Thus, the Work Group made the following recommendation: We recommend eletriptan, frovatriptan, rizatriptan, sumatriptan (oral or subcutaneous), the combination of sumatriptan and naproxen, or zolmitriptan (oral or intranasal) for the acute treatment of migraine.

Recommendation

20. We recommend aspirin/acetaminophen/caffeine for the acute treatment of migraine.
    (Strong for | Reviewed, New-added)

Discussion

Simple nonsteroidal anti-inflammatory drugs (NSAID), aspirin and acetaminophen as single agents are evidence-based options for the acute treatment of migraine and are further addressed in Recommendation 21. The combination product of aspirin, acetaminophen, and caffeine (AAC) was assessed in an SR by Diener et al. (2022),