### Key Points

<table>
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<th>Key Points</th>
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<td>Beware of the occipital headache.</td>
<td>Migraine headache is usually fronto-temporal. Occipital headache in children, whether unilateral or bilateral, is rare and calls for diagnostic caution and consideration of a structural lesion.</td>
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<td>Children are more likely than adults to have complex neurological presentations with migraine.</td>
<td>Unique from adults, children have defined precursors of migraine termed “the childhood periodic syndromes” and are more likely to have complex neurological presentations believed to be migraine variants.</td>
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<td>Family history of migraine is almost always present.</td>
<td>A family history is present in &gt; 70% of children with migraine, but, with the exception of familial hemiplegic migraine, the genetics remain unclear. Three gene defects have been found in patients with familial hemiplegic migraines. An association has been made between gene mutations associated with familial hemiplegic migraine and benign familial infantile convulsions. In a small case series of children with benign paroxysmal torticollis of infancy, one of the childhood periodic syndromes, two patients came from a kindred with familial hemiplegic migraine with a known genetic mutation.</td>
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<td>A complete neurological examination is essential to ruling out serious secondary causes of headache in children.</td>
<td>If the patient’s neurological examination is focal or abnormal, immediate neuroimaging is recommended. If there is a seizure associated with the patient’s headache, immediate neuroimaging is recommended. If the current headache is not similar to the patient’s previous migraine headaches, immediate neuroimaging is recommended. If neuroimaging is determined by the clinician to be necessary, MRI (if available) is a more complete tool to evaluate for abnormalities than computed tomography (CT).</td>
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<td>Laboratory testing for pediatric migraine headache is almost never necessary.</td>
<td>The AAN published a practice parameter on the “Evaluation of children and adolescents with recurrent headaches” in 2002. The guidelines’ section regarding laboratory studies in recurrent headaches referenced only one retrospective chart review from a neurology clinic evaluating referrals from pediatricians with the findings being “uniformly unrevealing.” However, this study does not identify the specific laboratory data for the evaluated subjects. Despite the limited evidence on the topic, routine laboratory evaluation in pediatric migraineurs is not recommended.</td>
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<td>Neuroimaging for pediatric migraine headache is necessary only in limited circumstances (seizure with headache, abnormal neurological examination).</td>
<td>The AAN practice parameter makes the following recommendations regarding neuroimaging: 1. Obtaining a neuroimaging study on a routine basis is not indicated in children with recurrent headaches and a normal neurologic examination. 2. Neuroimaging should be considered in children with an abnormal neurologic examination (eg, focal findings, signs of increased intracranial pressure, significant alteration of consciousness), the coexistence of seizures, or both. 3. Neuroimaging should be considered in children in whom there are historical features to suggest the recent onset of severe headache, change in the type of headache, or if there are features that suggest neurologic dysfunction.</td>
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<td>Multiple medications may be used for the treatment of pediatric migraine; however, ibuprofen, prochlorperazine, and the “triptans” have the most evidence supporting their use.</td>
<td>5-Hydroxy-tryptamine agonists (or “triptans”) are the most recent class of migraine-specific drugs developed for the abortive treatment of migraine headaches. This group of serotonin receptor agonists has revolutionized the treatment of migraines in the adult population, and many of the triptans have been studied in the pediatric patient. Although triptans are useful in the treatment of migraine, their efficacy is limited to those headaches of a relatively short duration (&lt; 6 hours) – a group of patients not often evaluated in the ED. Other than almotriptan, none of the triptans are FDA-approved for use in the pediatric patient, despite multiple studies demonstrating the safety of triptan use in children. As such, any suggestions regarding the use of triptans in pediatric migraine (as contained in this article) must be judged as “off-label.”</td>
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<td>Opioids (narcotics) have no role in the treatment of pediatric migraine.</td>
<td>According to Colman, the use of opioids in the treatment of migraine is “potentially ineffective and may lead to abuse.” The National Headache Foundation states that opioids are “reserved for patients with moderate to severe pain who do not respond to non-opioid medications.”</td>
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_EVIDENCE-BASED PRACTICE RECOMMENDATIONS_
REFERENCES


These references are excerpted from the original manuscript. For additional references and information on this topic, see the full text article at ebmedicine.net.

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