



Complete Summary

GUIDELINE TITLE

Head (trauma, headaches, etc., not including stress & mental disorders).

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Head (trauma, headaches, etc., not including stress & mental disorders). Corpus Christi (TX): Work Loss Data Institute; 2007 May 9. 150 p. [170 references]

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [July 19, 2006, Triptans](#): Healthcare professionals and consumers of new safety information regarding taking triptans together with selective serotonin reuptake inhibitors (SSRIs) and selective serotonin/norepinephrine reuptake inhibitors (SNRIs).

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **

SCOPE

METHODOLOGY - including Rating Scheme and Cost Analysis

RECOMMENDATIONS

EVIDENCE SUPPORTING THE RECOMMENDATIONS

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

CONTRAINDICATIONS

QUALIFYING STATEMENTS

IMPLEMENTATION OF THE GUIDELINE

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

CATEGORIES

IDENTIFYING INFORMATION AND AVAILABILITY

DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Work-related head trauma and headaches, not including stress and mental disorders

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Internal Medicine
Neurological Surgery
Neurology
Physical Medicine and Rehabilitation
Surgery

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To offer evidence-based step-by-step decision protocols for the assessment and treatment of workers' compensation conditions

TARGET POPULATION

Workers with occupational head trauma or headache

INTERVENTIONS AND PRACTICES CONSIDERED

The following interventions/procedures were considered and recommended as indicated in the original guideline document:

1. Activity restrictions/work
2. Acupuncture for headaches
3. Anticonvulsants

4. Assessment of concussion severity
5. Bed rest for severe traumatic brain injury (TBI)
6. Botulinum toxin type A
7. Chiropractic/manipulation for headache
8. Cognitive skills retraining
9. Cognitive/behavioral therapy
10. Computed tomography (CT)
11. Craniectomy/craniotomy for severe TBI
12. Cranioplasty
13. Electroencephalography (EEG) (neurofeedback)
14. Electrodiagnostic studies (electromyography [EMG], nerve conduction studies [NGS], dynamic electromyographies, evoked potential responses)
15. Fluid resuscitation
16. Glasgow Coma Scale (GCS)
17. Hearing aids
18. Hyperventilation
19. Hypothermia (mild)
20. Interdisciplinary rehabilitation programs
21. Lumbar puncture
22. Magnetic resonance imaging (MRI)
23. Manipulation for prophylactic treatment of headaches
24. Mannitol
25. Methylphenidate
26. Modified Ashworth Scale (MAS)
27. Multidisciplinary community rehabilitation
28. Neuropsychological testing
29. Nutrition
30. Occupational/physical therapy
31. Relaxation treatment (for migraines)
32. Return to work
33. Sedation
34. Sleep aids
35. Triptans for migraine sufferers
36. Vision evaluation
37. X-rays (skull) if CT not available

The following interventions/procedures are under study and are not specifically recommended:

1. Antidepressants
2. Branched-chain amino acids (BCAAs)
3. Cell transplantation therapy
4. Greater occipital nerve block (GONB)
5. Oxygen therapy
6. Positron emission tomography (PET)
7. Wilsonii injecta

The following interventions were considered, but are not recommended:

1. Corticosteroids (for acute traumatic brain injury)
2. Electrodiagnostic studies (electroretinogram [ERG], cognitive event-related potential, somatosensory evoked potential [SSEP])

3. Quantitative electroencephalogram (QEEG) (brain mapping)
4. Single photon emission computed tomography (SPECT)

MAJOR OUTCOMES CONSIDERED

- Sensitivity and specificity of diagnostic tests
- Effectiveness of treatments for relief of pain and symptoms

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Work Loss Data Institute (WLDI) conducted a comprehensive medical literature review (now ongoing) with preference given to high quality systematic reviews, meta-analyses, and clinical trials published since 1993, plus existing nationally recognized treatment guidelines from the leading specialty societies. WLDI primarily searched MEDLINE and the Cochrane Library. In addition, WLDI also reviewed other relevant treatment guidelines, including those in the National Guideline Clearinghouse, as well as state guidelines and proprietary guidelines maintained in the WLDI guideline library. These guidelines were also used to suggest references or search terms that may otherwise have been missed. In addition, WLDI also searched other databases, including MD Consult, eMedicine, CINAHL, and conference proceedings in occupational health (i.e. American College of Occupational and Environmental medicine [ACOEM]) and disability evaluation (i.e. American Academy of Disability Evaluating Physicians [AADEP], American Board of Independent Medical Examiners [ABIME]). Search terms and questions were diagnosis, treatment, symptom, sign, and/or body-part driven, generated based on new or previously indexed existing evidence, treatment parameters and experience.

In searching the medical literature, answers to the following questions were sought: (1) If the diagnostic criteria for a given condition have changed since 1993, what are the new diagnostic criteria? (2) What occupational exposures or activities are associated causally with the condition? (3) What are the most effective methods and approaches for the early identification and diagnosis of the condition? (4) What historical information, clinical examination findings or ancillary test results (such as laboratory or x-ray studies) are of value in determining whether a condition was caused by the patient's employment? (5) What are the most effective methods and approaches for treating the condition? (6) What are the specific indications, if any, for surgery as a means of treating the condition? (7) What are the relative benefits and harms of the various surgical and non-surgical interventions that may be used to treat the condition? (8) What is the relationship, if any, between a patient's age, gender, socioeconomic status and/or racial or ethnic grouping and specific treatment outcomes for the condition? (9) What instruments or techniques, if any, accurately assess functional limitations in an individual with the condition? (10) What is the natural

history of the disorder? (11) Prior to treatment, what are the typical functional limitations for an individual with the condition? (12) Following treatment, what are the typical functional limitations for an individual with the condition? (13) Following treatment, what are the most cost-effective methods for preventing the recurrence of signs or symptoms of the condition, and how does this vary depending upon patient-specific matters such as underlying health problems?

Criteria for Selecting the Evidence

Preference was given to evidence that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reports a cohort study, whether prospective or retrospective, or (5) The article reports a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

More information about the selection of evidence is available in "Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument" (see "Availability of Companion Documents" field).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Ranking by Type of Evidence

1. Systematic Review/Meta-Analysis
2. Controlled Trial-Randomized (RCT) or Controlled
3. Cohort Study-Prospective or Retrospective
4. Case Control Series
5. Unstructured Review
6. Nationally Recognized Treatment Guideline (from www.guideline.gov)
7. State Treatment Guideline
8. Other Treatment Guideline
9. Textbook
10. Conference Proceedings/Presentation Slides

Ranking by Quality within Type of Evidence

- a. High Quality
- b. Medium Quality

c. Low Quality

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Work Loss Data Institute (WLDI) reviewed each article that was relevant to answering the question at issue, with priority given to those that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reported a cohort study, whether prospective or retrospective, or (5) The article reported a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

Especially when articles on a specific topic that met the above criteria were limited in number and quality, WLDI also reviewed other articles that did not meet the above criteria, but all evidence was ranked alphanumerically (see the Rating Scheme of the Strength of Evidence field) so that the quality of evidence could be clearly determined when making decisions about what to recommend in the Guidelines. Articles with a Ranking by Type of Evidence of Case Reports and Case Series were not used in the evidence base for the Guidelines. These articles were not included because of their low quality (i.e., they tend to be anecdotal descriptions of what happened with no attempt to control for variables that might effect outcome). Not all the evidence provided by WLDI was eventually listed in the bibliography of the published Guidelines. Only the higher quality references were listed. The criteria for inclusion was a final ranking of 1a to 4b (the original inclusion criteria suggested the methodology subgroup), or if the Ranking by Type of Evidence was 5 to 10, the quality ranking should be an "a."

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Prior to publication, select organizations and individuals making up a cross-section of medical specialties and typical end-users externally reviewed the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary. The recommendations that follow are based on the previous version of the guideline.

Initial Diagnosis and Treatment -- Head Injuries

The first priority for the head-injured patient is complete and rapid physiologic resuscitation.

Most minor injuries will regain normal consciousness in the field or emergency department, and if the patient has normal neurological findings on examination and neuroradiological studies when appropriate, he/she may be discharged home with close supervision for the initial twenty-four hours.

Sedation and neuromuscular blockade can be useful in optimizing transport of the head injury patient. However, both treatments interfere with the neurological examination.

Initial Diagnosis

In addition to a physical examination by a practiced practitioner, the following should be part of the process to determine the initial diagnosis in a head-injured patient:

Glasgow Coma Scale Score

The Glasgow Coma Scale (GCS) when performed in the emergency department may aid in predicting the level of traumatic brain injury. Individuals with mild traumatic brain injuries may have a normal score on the GCS. Serial GCS scores may be helpful when intoxication may be a factor.

Neurological Examination

A neurological examination and neuropsychological assessment should be performed by a qualified practitioner to evaluate central nervous system function and diagnose specific behavioral or cognitive deficits or disorders.

Imaging

Computed axial tomography (CT) is a well-established, non-invasive brain imaging x-ray study that should reveal the presence of blood, skull fracture, and/or

structural changes in the brain. It should be performed on all patients sustaining a transient neurologic deficit secondary to trauma.

Magnetic resonance imaging (MRI) scans are more sensitive than CT for detecting traumatic cerebral injury. Initially, MRI scans are clinically useful in the following situations to:

- Determine neurological deficits not explained by CT
- Evaluate prolonged interval of disturbed consciousness
- Define evidence of acute changes super-imposed on previous trauma or disease

Lumbar Puncture

Lumbar puncture is a well-established diagnostic procedure for examination of cerebrospinal fluid (CSF) in neurological disease and injury. The procedure should be performed by qualified and trained physicians under sterile conditions.

Indications for lumbar puncture:

- Neurological disease and injury with no radiographic evidence of extra-axial hemorrhage, mass effect, or impending brain herniation
- With suspected or known increased intra-cranial pressure, lumbar puncture should be preceded by fundoscopic examination and by a CT scan or MRI.
- Adult patients with headache exhibiting signs of increased intracranial pressure including papilledema, absent venous pulsations on fundoscopic examination, altered mental status, or focal neurologic deficits should undergo a neuroimaging study before having a lumbar puncture.

Contraindications for lumbar puncture:

- Acute trauma to the spinal column
- Certain infections
- Increased intracranial pressure due to space occupying lesions
- Some coagulation disorders or defects
- Cutaneous infections in the region of the puncture site
- If CT or MRI shows intracerebral, intra-ventricular, or subarachnoid blood, lumbar puncture should be withheld until neurological consultation is obtained.

Official Disability Guidelines (ODG) Return-To-Work Pathways

Concussion

Mild concussion: 3 to 7 days

Severe concussion, non-cognitive/modified work: 14 days to indefinite

Severe concussion, cognitive work: 84 days to indefinite

Skull fracture

Without brain injury, clerical/modified work: 7 days

Manual work: 21 days

Heavy manual work: 49 days

(See ODG Capabilities & Activity Modifications for Restricted Work under "Work" in Procedure Summary of the original guideline document)

Initial Management

Hypotension

Hypotension (systolic blood pressure [SBP] <90 mm Hg) or hypoxia (apnea, cyanosis, or an oxygen (O₂) saturation <90% in the field or a PaO₂ <60 mm Hg) must be monitored and scrupulously avoided, if possible, or corrected immediately in severe traumatic brain injury patients.

- Mean arterial blood pressure should be maintained above 90 mm Hg through the infusion of fluids throughout the patient's course to attempt to maintain cerebral perfusion pressure (CPP) greater than 60 mm Hg.
- Patients with a Glasgow Coma Scale (GCS) score less than 9, who are unable to maintain their airway or who remain hypoxemic despite supplemental O₂, require that their airway be secured, preferably by endotracheal intubation.

Hypertension

If there are signs of transtentorial herniation or progressive neurological deterioration (not attributable to extracranial explanations) assume that intracranial hypertension is present and treat it aggressively. Hyperventilation should be rapidly established.

Hyperventilation

In the absence of increased intracranial pressure (ICP), avoid unnecessary or prophylactic hyperventilation (PaCO₂ less than 26), in the first 24-hours after injury.

Hyperventilation therapy may be necessary for brief periods when there is:

- Acute neurologic deterioration not attributable to systemic pathology (i.e., hypotension)

Hyperventilation therapy may be necessary for longer periods if there is:

- Intracranial hypertension refractory to sedation
- Paralysis
- Cerebrospinal fluid drainage

- Osmotic diuretics

Intracranial Pressure (ICP)

Intracranial pressure should be monitored in all patients with severe head injury following an abnormal CT scan. Abnormal findings may include one or more of the following:

- Hematomas
- Contusions
- Edema
- Compressed basal cisterns

In the absence of abnormal CT findings, ICP should also be monitored if two or more of the following are noted at admission:

- Patient is over 40 years old
- Unilateral or bilateral motor posturing
- Systolic blood pressure of less than 90 mm Hg

Interpretation and treatment of ICP should be corroborated by frequent clinical examination and cerebral perfusion pressure (CPP) data. In general, it is desirable to:

- Maintain ICP less than 20 to 25 mm Hg.
- Maintain mean arterial pressure (MAP) above 90.
- Maintain CPP (MAP at head level minus ICP) at or above 70 mm Hg.

Mannitol in doses ranging from 0.25 g/kg to 1 g/kg body weight is effective for control of raised ICP after severe head injury.

Mild or moderate head injury does not need to be monitored for ICP unless the conscious patient has traumatic mass lesions.

Cerebral Perfusion Pressure (CPP)

CPP should be maintained at a minimum of 60 mm Hg. In the absence of cerebral ischemia, aggressive attempts to maintain cerebral perfusion pressure above 70 mm Hg with fluids and pressors should be avoided because of the risk of adult respiratory distress syndrome.

Nutrition

Nutritional support should be aggressively initiated as soon as practicable. Preferable route is jejunal by gastrojejunostomy.

Anticonvulsants

Anticonvulsant treatment may be used to prevent early posttraumatic seizures in the high-risk individual, and are usually administered for one week in those with intracranial hemorrhage.

Prevention of early seizures has no statistically significant impact on long-term outcome or the development of late seizures or chronic epilepsy although the prevention of early seizures usually helps to reduce seizure-associated complications during acute management.

Operative Procedures

Craniectomy

Recommended for diffuse brain swelling, midline shift, and/or elevated ICP refractory to medical management and not fully alleviated by evacuation of mass lesion/hematoma (or in the absence of mass lesion/hematoma) -- (bone flap stored in freezer, or in the individual's abdominal wall).

Craniotomy

If there is immediate onset of total facial paralysis or if the electroneuronography (EnoG) shows greater than 90% degeneration of the facial nerve, exploration of the path of the facial nerve is indicated. This usually involves a middle fossa craniotomy and mastoidectomy in order to completely decompress the facial nerve.

ODG Return-To-Work Pathways

Without neurologic deficit, medical treatment: 14 days

Aneurysmectomy, clerical/modified work: 28 days

Aneurysmectomy, manual work: 42 days

Craniectomy, clerical/modified work: 28 days

Craniectomy, manual work: 42 days

Craniotomy, clerical/modified work: 28 days

Craniotomy, manual work: 42 days

Long-term Management

Postconcussion Syndrome

Approximately 38% of patients who sustain head trauma characterized by a brief disturbance of consciousness and clinically unremarkable neuroradiologic findings meet International Classification of Diseases 10th edition (ICD-10) diagnostic criteria for postconcussion syndrome (PCS). Symptoms could involve complaints of irritability, fatigue, headache, difficulty concentrating, dizziness and memory problems. Anxiety and depression are also frequently present, especially later in its course.

Although PCS has often been thought to reflect a psychological response to injury, there is considerable recent evidence to suggest that it is primarily a physiologic disturbance. For most individuals, treatment consists primarily of education of the patient and his/her family, along with supportive counseling regarding emerging problems at work or at home. A subgroup of patients, however, may require psychopharmacologic intervention.

Widely accepted treatments for post-traumatic headache may include, but are not limited to, interdisciplinary treatment, pharmacology, joint manipulation, physical therapy, massage, acupuncture, biofeedback, psychotherapy, and diet. These procedures should only be continued if functional gains are documented.

Electroencephalography (EEG)

Electroencephalography (EEG) is not generally indicated in the immediate period of emergency response, evaluation, and treatment. Following initial assessment and stabilization, the individual's course should be monitored. If during this period there is failure to improve, or the medical condition deteriorates, an EEG may be indicated to assist in the diagnostic evaluation.

Physical Therapy

Patient rehabilitation after traumatic brain injury is divided into two periods: acute and subacute. In the beginning of rehabilitation, physical therapist evaluates patient's functional status; later he uses methods and means of treatment and evaluates effectiveness of rehabilitation. Early verticalisation is very important for patients with coma. Physical therapy consists of prevention of complications, improvement of muscle force and range of motions, balance, movement coordination, endurance, and cognitive functions. Early rehabilitation is necessary for traumatic brain injury patients and use of physical therapy methods can help to regain lost functions and to come back to the society.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

During the comprehensive medical literature review, preference was given to high quality systematic reviews, meta-analyses, and clinical trials over the past ten years, plus existing nationally recognized treatment guidelines from the leading specialty societies.

The heart of each Work Loss Data Institute guideline is the Procedure Summary (see the original guideline document), which provides a concise synopsis of effectiveness, if any, of each treatment method based on existing medical evidence. Each summary and subsequent recommendation is hyper-linked into the studies on which they are based, in abstract form, which have been ranked, highlighted and indexed.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

These guidelines unite evidence-based protocols for medical treatment with normative expectations for disability duration. They also bridge the interests of the many professional groups involved in diagnosing and treating work-related head trauma or headaches.

POTENTIAL HARMS

- Hypothermia increases the risk of pneumonia and has other potentially harmful side effects.
- All patients taking methylphenidate should be monitored because a few individuals experienced significant changes in vital signs and adverse effects.

CONTRAINDICATIONS

CONTRAINDICATIONS

Contraindications for lumbar puncture:

- Acute trauma to the spinal column
- Certain infections
- Increased intracranial pressure due to space occupying lesions
- Some coagulation disorders or defects
- Cutaneous infections in the region of the puncture site
- If computed tomography (CT) or magnetic resonance imaging (MRI) shows intracerebral, intra-ventricular, or subarachnoid blood, lumbar puncture should be withheld until neurological consultation is obtained.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The Treatment Planning sections outline the most common pathways to recovery, but there is no single approach that is right for every patient and these protocols do not mention every treatment that may be recommended. See the Procedure Summaries (in the original guideline document) for complete lists of the various options that may be available, along with links to the medical evidence.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Head (trauma, headaches, etc., not including stress & mental disorders). Corpus Christi (TX): Work Loss Data Institute; 2007 May 9. 150 p. [170 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 (revised 2007 May 9)

GUIDELINE DEVELOPER(S)

Work Loss Data Institute - Public For Profit Organization

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Editor-in-Chief, Philip L. Denniston, Jr. and Senior Medical Editor, Charles W. Kennedy, MD, together pilot the group of approximately 80 members. See the ODG *Treatment in Workers Comp* [Editorial Advisory Board](#).

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

There are no conflicts of interest among the guideline development members.

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

GUIDELINE AVAILABILITY

Electronic copies of the updated guideline: Available to subscribers from the [Work Loss Data Institute Web site](#).

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Background information on the development of the Official Disability Guidelines of the Work Loss Data Institute is available from the [Work Loss Data Institute Web site](#).
- Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument. Available to subscribers from the [Work Loss Data Institute Web site](#).

PATIENT RESOURCES

The following is available:

- Appendix B. ODG Treatment in Workers' Comp. Patient information resources. 2006.

Electronic copies: Available to subscribers from the [Work Loss Data Institute Web site](#).

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material

and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on April 6, 2006. This summary was updated by ECRI on August 29, 2006, following the U.S. Food and Drug Administration advisory on Triptans, SSRIs, and SNRIs. This NGC summary was updated by ECRI on November 9, 2006, March 29, 2007 and August 27, 2007.

COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at <http://www.guideline.gov/about/inclusion.aspx> .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 9/15/2008

