Changing the Way We Work Community of Practice for Ontario Family Physicians

Nov 21, 2025

Dr. Zain Chagla
Dr. Danny Adel Monsour

Infectious Disease & Migraine Updates

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of
Family Physicians

Infectious Disease & Migraine Updates

Moderator:

- **Dr. Eleanor Colledge**, CPD Program Director, University of Toronto and Family Physician, South East Toronto Family Health Team, Toronto, ON

Panelists:

- **Dr. Zain Chagla**, Co-Medical Director Infection Control and Head of Infectious Diseases Service, Infectious Disease Physician, St. Joseph's Healthcare Hamilton, Hamilton, ON
- **Dr. Danny Adel Monsour**, Medicine Director, Axon Institute for Headache and Neurological Sciences, Oakville; Assistant Clinical Professor (Adjunct), McMaster University, Hamilton; Consultant Neurologist, UHN Intracranial Hypotension Program, Toronto, ON

Host:

- **Dr. Jobin Varughese**, OCFP President, Family Physician, Interim Assistant Dean of Primary Care Education for the School of Medicine at Toronto Metropolitan University (TMU), Brampton, ON

Session slides will be available on the CTWWW website by the end of the day.

The Changing the Way We Work Community of Practice for Ontario Family Physicians has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 32 Mainpro+ Certified Activity credits.

Self-learning program

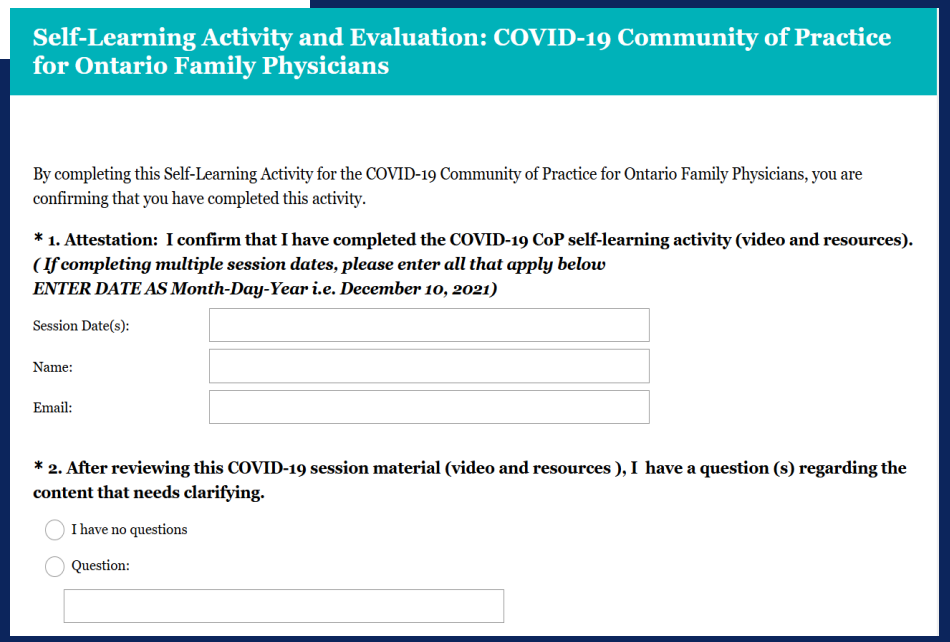
The session materials, including recordings, tools, and resources are available as self-learning modules.

This one-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 80 credits.

To participate in this self-learning:

- Select the dates/sessions you wish to participate in. You are welcome to complete as many sessions as you wish.
- Watch the video recording of the live session.
- Review the session tools and resources.
- Complete the self-learning post-session activity, click the button below.

Complete self-learning activity



Self-Learning Activity and Evaluation: COVID-19 Community of Practice for Ontario Family Physicians

By completing this Self-Learning Activity for the COVID-19 Community of Practice for Ontario Family Physicians, you are confirming that you have completed this activity.

*** 1. Attestation: I confirm that I have completed the COVID-19 CoP self-learning activity (video and resources).**
(If completing multiple session dates, please enter all that apply below
ENTER DATE AS Month-Day-Year i.e. December 10, 2021)

Session Date(s):

Name:

Email:

*** 2. After reviewing this COVID-19 session material (video and resources), I have a question (s) regarding the content that needs clarifying.**

I have no questions

Question:

Missed a session? Want to earn credits?

The Self-learning Program lets you earn credits for watching past sessions.

Just click the link and fill out a 60s form!

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.

Changing the way we work

A community of practice for family physicians

At the conclusion of this series participants will be able to:

- Identify the current best practices for delivery of primary care and how to incorporate into practice.
- Describe point-of-care resources and tools available to guide decision making and plan of care.
- Connect with a community of family physicians to identify practical solutions for their primary care practice under current conditions.

Disclosure of Financial Support

This CPD program has received in-kind support from the Ontario College of Family Physicians and the Department of Family and Community Medicine, University of Toronto in the form of logistical and promotional support.

Potential for conflict(s) of interest:
N/A

Mitigating Potential Bias

- The Scientific Planning Committee has full control over the choice of topics/speakers.
- Content has been developed according to the standards and expectations of the Mainpro+ certification program.
- The program content was reviewed by a three-member national/scientific planning committee.

Planning Committee: Dr. Jobin Varughese (OCFP), Dr. Ali Damji (DFCM), Dr. Eleanor Colledge (DFCM), Dr. Harry O'Halloran, Julia Galbraith (OCFP), Pavethra Yogeswaran (OCFP), Marisa Schwartz (DFCM), Erin Plenert (DFCM)

Previous webinars & related resources:

https://dfcm.utoronto.ca/past-changing-way-we-work-community-practice-sessions

Dr. Zain Chagla – Panelist

Co-Medical Director Infection Control and Head of Infectious Diseases Service; Infectious Disease Physician, St. Joseph's Healthcare Hamilton

Dr. Danny Adel Monsour – Panelist

Medicine Director, Axon Institute for Headache & Neurological Sciences; Assistant Clinical Professor (Adjunct), McMaster University; Consultant Neurologist, UHN Intracranial Hypotension Program

Speaker Disclosure

- Faculty Name: **Dr. Zain Chagla**
- Relationships with financial sponsors:
    - Grants/Research Support: Merck, Pfizer
    - Speakers Bureau/Honoraria: GSK, Avir, Ferring, Merck, Pfizer, Moderna, AstraZeneca, Takeda, Paladin, Ontario College of Family Physicians
    - Others: N/A

- Faculty Name: **Dr. Danny Adel Monsour**
- Relationships with financial sponsors:
    - Grants/Research Support: N/A
    - Speakers Bureau/Honoraria: Ontario College of Family Physicians, Searchlight/Miravo, Lundbeck, Abbvie, Novartis, Eli Lilly, Teva, Pfizer, Canadian Headache
    - Membership on advisory boards or speakers' bureaus: Lundbeck, Abbvie, Searchlight/ Miravo, Eli Lilly, Pfizer, LinPharma, Organon, Teva
    - Others: Founder, Medical Director of Axon Institute for Headache and Neurological Sciences, Oakville, ON; Member, Medical Advisory Board of Spinal CSF Leak Canada

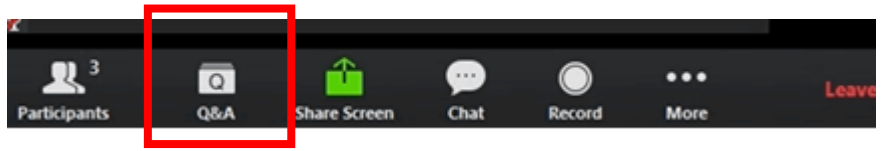
Speaker Disclosure

- Faculty Name: **Dr. Jobin Varughese**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: Toronto Metropolitan University, School of Medicine (Interim Assistant Dean of Primary Care Education)

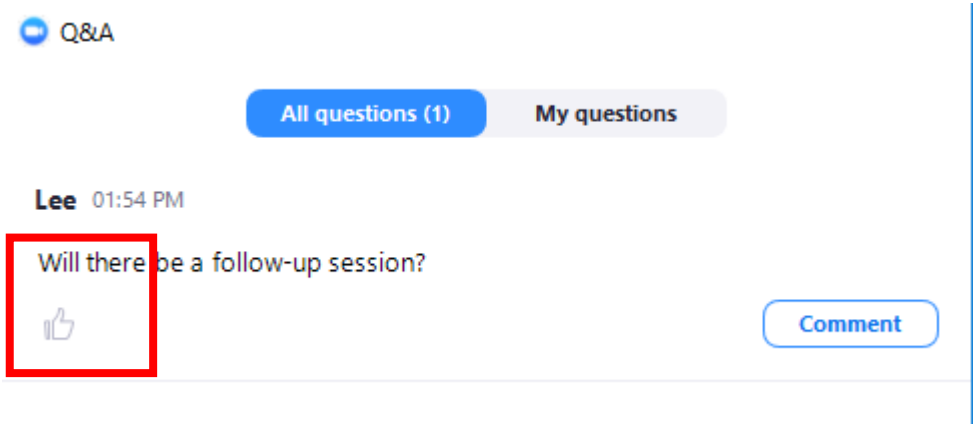
- Faculty Name: **Dr. Eleanor Colledge**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: The Foundation for Medical Practice Education (McMaster University)

How to Participate

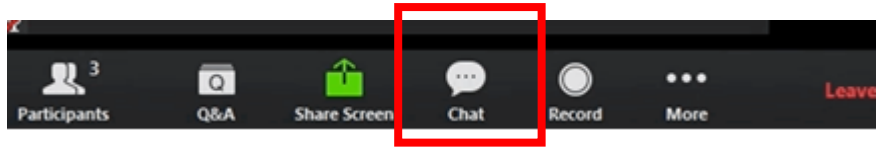
- All questions should be asked using the Q&A function at the bottom of your screen.



- Press the thumbs up button to upvote another guest's questions. Upvote a question if you want to ask a similar question or want to see a guest's question go to the top and catch the panels attention.



- Please use the chat box for networking purposes only.



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Respiratory Season Update 2025–26

Zain Chagla, MD

Infectious Diseases

St. Joseph's Healthcare Hamilton / McMaster University

Today's Objectives

Current Epidemiology

Review the landscape of RSV, influenza, and COVID-19 circulation patterns across Ontario during the 2024–25 respiratory season

Vaccine Recommendations

Summarize updated eligibility criteria, timing, and product selection for seasonal respiratory vaccines

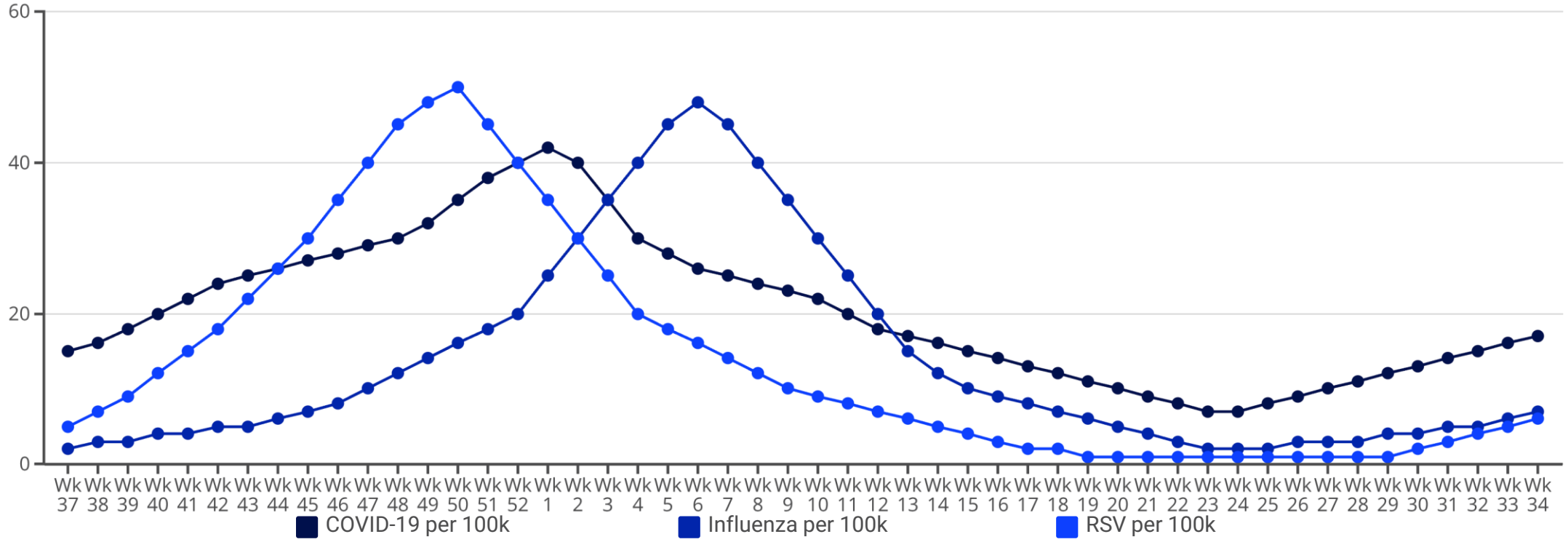
COVID-19 and Influenza Therapeutics

Outline evidence-based treatment options for high-risk patients presenting within the therapeutic window

Infection Prevention

Discuss practical, office-based strategies to reduce transmission and protect vulnerable populations

Respiratory Season Epidemiology (Hospitalizations for infection) 2024-2026



This line chart illustrates the circulation patterns of key respiratory viruses across the 2024-25 season, showing cases per 100,000 population for standardized comparison. RSV demonstrated early season activity, peaking around late December/early January. Influenza followed a classic winter circulation pattern, with peak activity observed from late January through February. COVID-19 maintained a consistent presence throughout the entire season, exhibiting notable peaks that coincided with major holiday periods.

RSV Vaccination Strategy

Adult Vaccination

Eligibility Criteria

Adults **≥60 years** (licensed age range) or **50-74 years** with risk factors (cardiac, pulmonary, immunocompromise, frailty).

Ontario Public Funding: For adults **≥75 years**. Some 60–74-year-olds also eligible (e.g., congregate care, dialysis, transplant, homeless).

Which Vaccine to Give?

- Abrysvo or Arexvy for adults ≥60 years (supply not limited)

Pregnancy & Infant Protection

- **Pregnancy:** Abrysvo at 32-36 weeks gestation for passive immunity (DO NOT GIVE AREXVY).
- **Infants:** Universal nirsevimab program for all infants entering first RSV season (born ≥April 1, 2025).

Real World Data

Test Negative US Data

Kaiser permanente – ED / Hospilization for ED

- VE was 92% (95% confidence interval, 64%–98%)
- with risk conditions (92% [95% confidence interval: 65%–98%])
- the oldest subgroup (age ≥75 years; 95% [60%–99%]), those with critical outcomes (intensive care unit admission, mechanical ventilation, respiratory failure, vasopressor use, or death; 90% [16%–99%])
- and those with severe disease (defined as ED visit or hospitalization requiring oxygen; 92% [35%–99%]).

Danish RSV RCT

VE for hospitalization – 83.3%

VE for respiratory tract disease from any cause 15.2%

All cause reduction in cardiorespiratory hospitalization (VE 9.9%)

Influenza Vaccination 2024–25

Universal Recommendation

Annual influenza vaccination is recommended for everyone **≥6 months of age** without contraindications. This broad approach maximizes community protection and reduces disease transmission across all age groups.

Enhanced Vaccines for Older Adults

Adults **≥65 years** should receive enhanced formulations: high-dose trivalent inactivated vaccine (HD-TIV) or adjuvanted trivalent inactivated vaccine (aTIV). These formulations provide superior immunogenicity in this age group.

Live Attenuated Option

Live attenuated influenza vaccine (LAIV) remains an option for eligible individuals aged **2–59 years**. LAIV offers needle-free administration and may improve vaccine acceptance in pediatric populations.

Seasonal Timing

Ontario's expected influenza activity window spans **November through March**. Optimal vaccination timing is October through early November to ensure peak immunity during circulation periods.

Influenza Vaccine Effectiveness

Meta-analysis (Yegerov et al, CMI, 2025)

- 42% (95% CI: 39–44) against influenza-associated hospitalization
- 36% (95% CI: 24–46) against death
- 51% (95% CI: 36–63) against pneumonia
- 52% (95% CI: 38–63) against intensive care unit admission
- 55% (95% CI: 44–64) against ventilatory support

RCT of High-dose flu vaccine vs. standard (Johansen et al, et al, NEJM, 2025)

- 3 years, ~300,000 randomized participants
- Relative vaccine efficacy for influenza hospitalization: 43%
- Relative vaccine efficacy for cardiovascular hospitalization: 5%

COVID-19 Vaccination

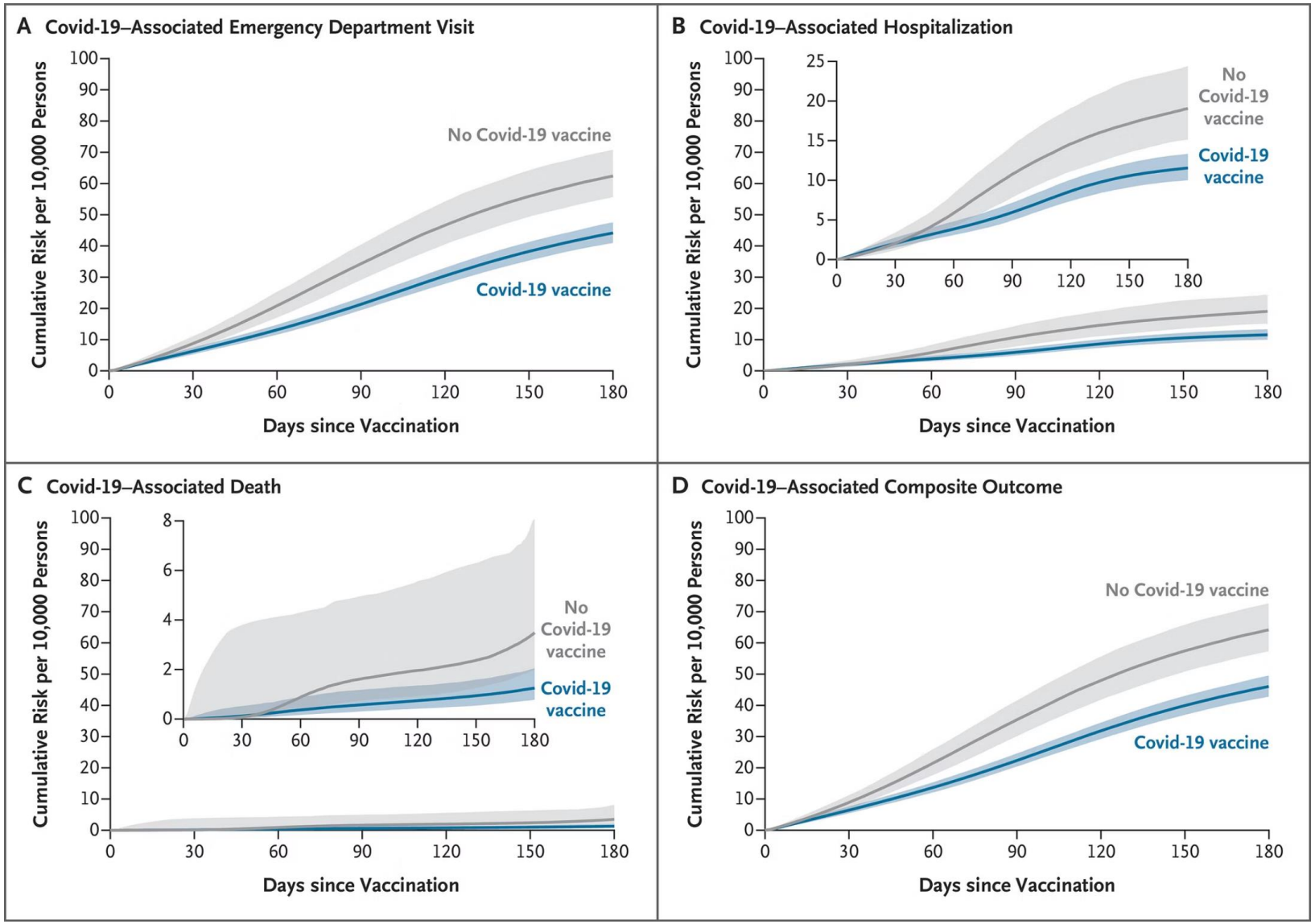
Updated Formulations

Updated **monovalent JN1-lineage formulations**.

Priority Populations

Prioritize vaccination for adults **≥65 years**, individuals who are immunocompromised, those with chronic medical conditions (cardiac, pulmonary, metabolic, renal disease), marginalized/high risk communities and pregnant individuals at any trimester, healthcare workers

Real World Evidence (Cai et al, NEJM, 2025)



Office Practice & Infection Prevention

Masking Protocols

Encourage masks for symptomatic patients during peak respiratory season. Provide masks at entry points and in waiting areas. Consider staff masking during high community transmission weeks to reduce workplace absenteeism.

Symptom Triage

Implement rapid symptom screening at check-in. Use verbal or digital screening tools to identify potentially infectious patients. Consider separate waiting areas or rapid rooming for symptomatic individuals.

Opportunistic Vaccination

Leverage routine office visits to review and update respiratory vaccines. Standing orders and electronic prompts improve vaccination rates. Every clinical encounter is an opportunity to close immunization gaps.

Environmental Controls

Deploy HEPA filtration units in waiting rooms and examination areas where possible. Improve ventilation by increasing fresh air exchange rates. These engineering controls reduce airborne pathogen concentration.

Staff Protection

Staff masking during high circulation periods substantially reduces employee absenteeism and maintains practice continuity. Ensure all staff are up-to-date with seasonal vaccines and have access to appropriate PPE.

Key Takeaways

1

Triple Threat Season

RSV, influenza, and COVID-19 co-circulate during fall and winter months. Understanding epidemiology patterns helps target prevention efforts and optimize clinical decision-making.

2

Vaccination Remains Cornerstone

Updated respiratory vaccines provide substantial protection against severe outcomes. Prioritize high-risk groups while maintaining universal influenza recommendations.

3

Early Intervention Matters

COVID-19 therapeutics are most effective when initiated early. Ensure systems support rapid testing and clinical assessment for eligible high-risk patients.

4

Layered Office Strategies

Combine masking, ventilation, triage protocols, and opportunistic vaccination to create comprehensive infection prevention in primary care settings.

Questions?

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Migraine in Primary Care:

A Practical, Modern Approach to Diagnosis and Treatment

Danny Adel Monsour, MD, FRCPC, Neurology and Headache Medicine

Director, Axon Institute for Headache and Neurological Sciences

Assistant Clinical Professor (Adjunct), McMaster University

Consultant Neurologist, UHN Intracranial Hypotension Program

November 21, 2025

Learning Objectives

- After attending the session, participants will be better able to:

1

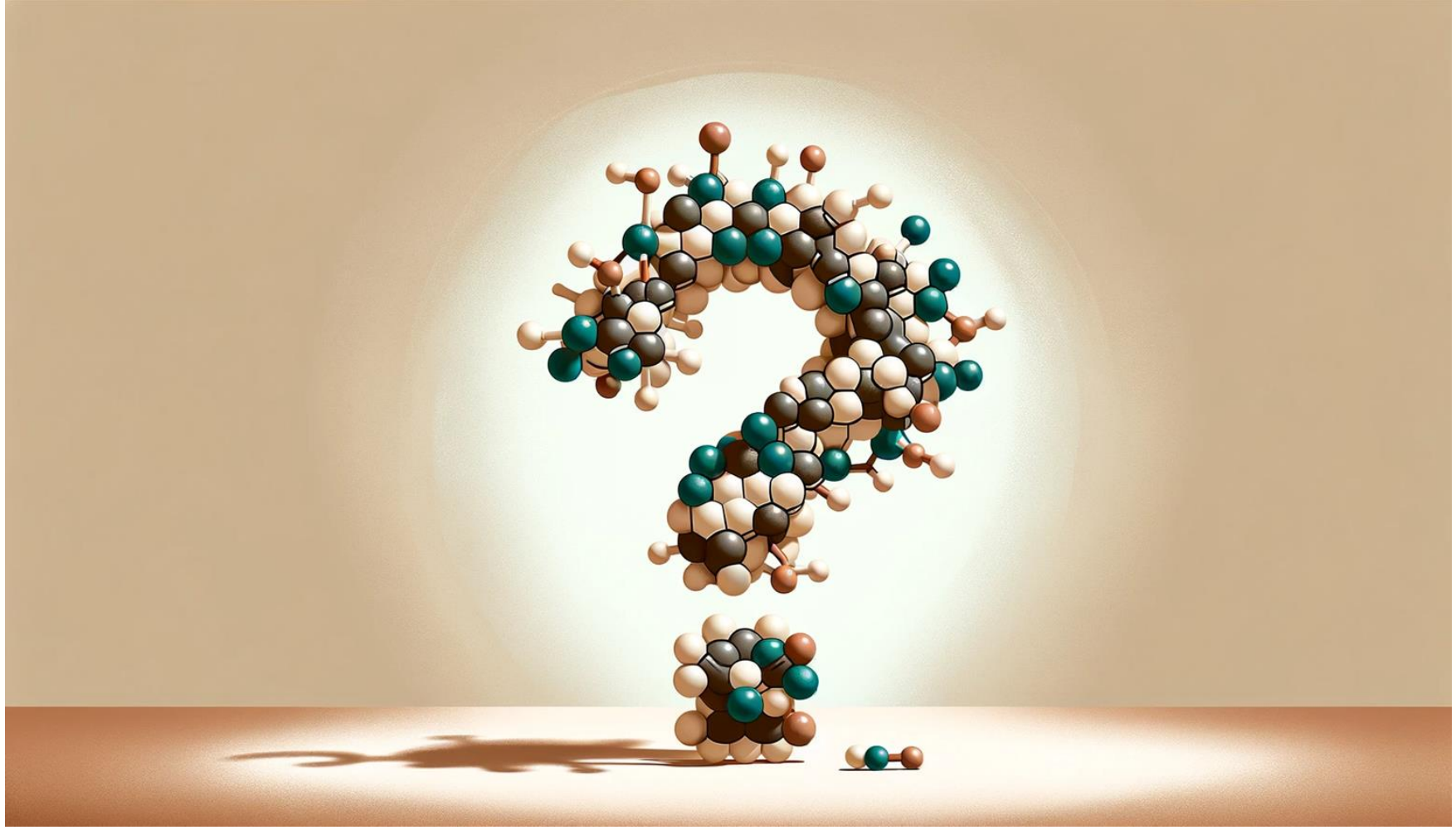
Diagnose migraine efficiently using the PIN tool and streamlined clinical criteria.

2

Apply updated acute and preventive treatment options—including new CGRP-targeted therapies—based on current evidence and patient profiles.

3

Use a structured 10-minute migraine consult approach to guide assessment, treatment decisions, and follow-up in primary care.



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Rapid Migraine Diagnosis

Confirm the migraine diagnosis: **PIN screening**

P

Photophobia
Did light bother you when you had a headache (a lot more than when you do not have headaches)?

I

Impairment
In the last 3 months, did your headache limit your ability to work, study, or do what you needed to do for at least 1 day?

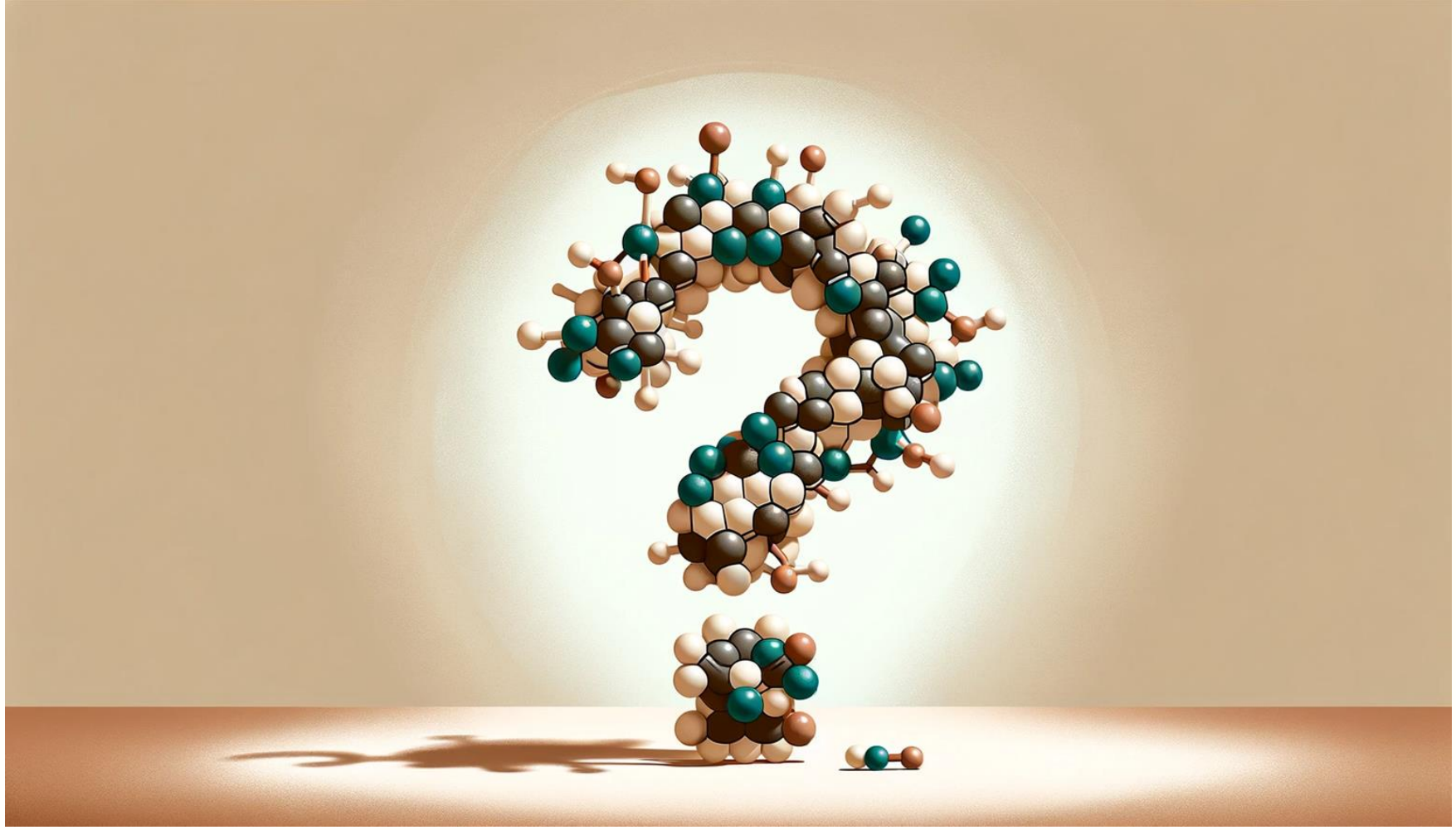
N

Nausea
Did you feel nauseated or sick to your stomach with your headaches?

After excluding red flags, if the patient answers yes to ≥2 PIN questions, they are likely to have migraine.

- ***Sensitivity: 0.81***
- ***Specificity: 0.75***
- ***Positive predictive value: 0.93***

1. Lipton RB et al. *Neurology*. 2003;61:375–382. 2. Karli N et al. *The Journal of Headache and Pain*. 2007;8(4):217-223.



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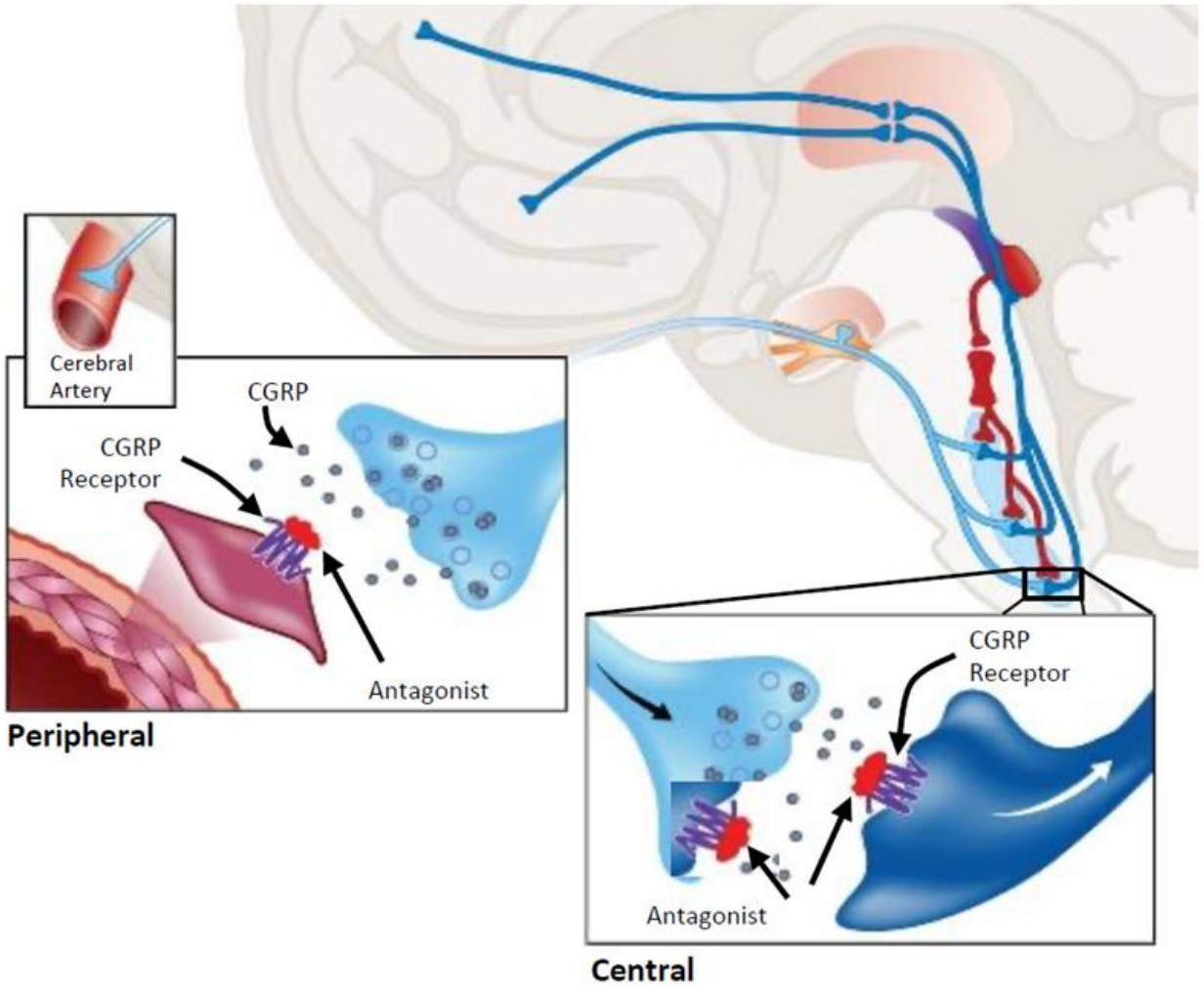
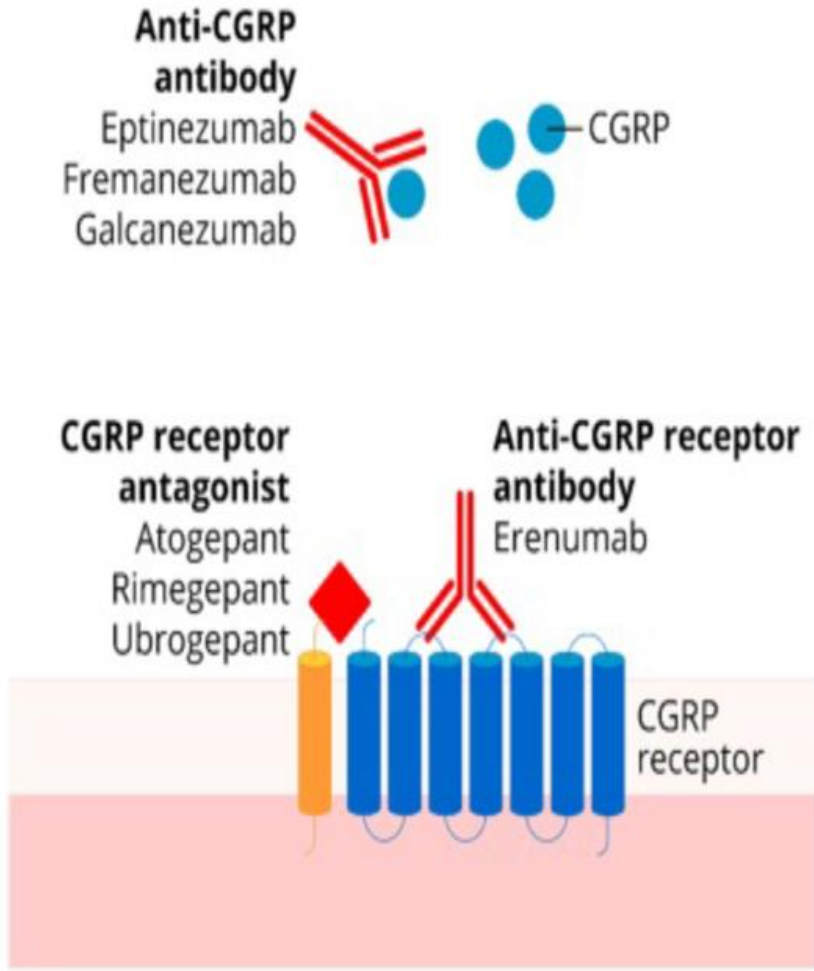
The CGRP Era: A New Class of Migraine Treatments

Novel Migraine Target: What is Calcitonin-Gene Related Peptide (CGRP)?





Modified from Thien PD et al. J Headache and Pain 2019;20.

Gepants Approved for **Acute** Treatment of Migraine in Canada

	Rimegepant (NURTEC® ODT)	Ubrogepant (UBRELVY®)
Company	Pfizer	AbbVie
Approval date	December 2023	November 2022
Indication	Acute treatment of migraine with or without aura in adults	
Formulation	Orally disintegrating tablet (ODT)	Oral tablet
Dosing		
Recommended dose	75 mg ODT, as needed, once daily	50 mg or 100 mg taken orally, with or without food If needed, an optional second dose may be taken at least 2 hours after the initial dose
Maximum daily dose	75 mg	200 mg
Dosing considerations	• No dosage adjustment required in: – Mild, moderate, or severe renal impairment – Mild or moderate hepatic impairment (Child-Pugh A or B) • Avoid in ESRD (CrCl <15 mL/min), patients on dialysis and in severe hepatic impairment	• Dose adjustments are recommended in patients who: – Are elderly – Have severe hepatic (Child-Pugh Class C) or renal (CrCl 15-29 mL/min) impairment – Are taking mild or moderate CYP3A4 inhibitors or inducers, as well as BCRP inhibitors and/or P-gp only inhibitors • Consumption of a high-fat meal delays ubrogepant peak plasma concentrations
Key phase 3 trials	Study 303	ACHIEVE I and II

BCRP, breast cancer resistance protein; CrCl, creatinine clearance; CYP3A4, cytochrome P450 3A4; ESRD, end-stage renal disease; min, minute; P-gp, glycoprotein P.

PrNURTEC® ODT (rimegepant orally disintegrating tablets). Kirkland, QC. Pfizer Canada ULC. December 1, 2023; PrUBRELVY® (ubrogepant tablets). Saint-Laurent, QC. AbbVie Corporation. November 10, 2022; Croop R et al. Lancet. 2019;394:737-745; Dodick DW et al. New Eng J Med. 2019;381:2230-2241; Lipton RB et al. JAMA. 2019;322(19):1887-1898.

Revisiting the acute treatment guidelines

- Where do the GEPANTS fit?

1st line

2nd line

3rd line?

Last resort

	Drug	Route	Recommendation
NSAIDs	Diclofenac potassium for oral solution	Oral	Strong
	Diclofenac potassium tablets	Oral	Strong
	ASA	Oral	Strong
	Ibuprofen	Oral	Strong
	Naproxen sodium	Oral	Strong
Other	Acetaminophen	Oral	Strong
Triptans	Almotriptan	Oral	Strong
	Eletriptan	Oral	Strong
	Frovatriptan	Oral	Strong
	Naratriptan	Oral	Strong
	Rizatriptan	Oral	Strong
	Sumatriptan	SC, Oral, Intranasal	Strong
	Zolmitriptan	Oral, Intranasal	Strong
Ergots	Dihydroergotamine	Intranasal, SC	Weak
	Ergotamine (no longer available)	Oral	Weak (not recommended routine use)
Opioids Tramadols	Opioid-containing medications	Oral	Weak (not recommended routine use)
	Tramadol-containing medications	Oral	Weak (not recommended routine use)

Adapted from: Worthington *et al*. *Can J Neurol Sci* 2013;40:S1-S80

Anti-CGRP mAbs Approved for **Preventative** Treatment of Migraine

	2022	2018	2021	2019
	Eptinezumab	**Erenumab**	**Fremanezumab**	**Galcanezumab**
Target	Ligand	Receptor	Ligand	Ligand
Subclass	Humanized	Human	Humanized	Humanized
Production	Yeast	Chinese hamster ovary	Chinese hamster ovary	Chinese hamster ovary
Dose	100-300 mg IV every 3 months	70 or 140 mg subcutaneous monthly	225 mg subcutaneous monthly (most common) or 675 mg subcutaneous every 3 months	240 mg subcutaneous loading dose, then 120 mg subcutaneous monthly
Time to maximum (T_{max})	2-5 hours	5.5 days	5-7 days	7-13 days
Half-life	27 days	21-23 days	31 days	28 days
Notes	IV administration leads to fastest onset of efficacy	Clinical experience suggests higher risk of constipation than with other monoclonal antibodies	Higher risk of injection site reactions than for erenumab; quarterly dosing may be convenient for some patients	Higher risk of injection site reactions than for erenumab

IV = intravenous.
[a] Data from Do TP, et al, J Headache Pain.[21]

Canadian Access Parameters:

- Failure/Intolerance of >2 oral preventatives for migraine (>4 migraine days/mo)
- OOP: >$500/mo
- Third Party Payers: >90% approval
- EAP for EM/CM:
  - Fremanezumab
  - Galcanezumab
  - Eptinezumab

Gepants Approved for **Preventative** Treatment of Migraine in Canada

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Atogepant for the Preventive Treatment of Migraine

Jessica Ailani, M.D., Richard B. Lipton, M.D., Peter J. Goadsby, M.D., Hua Guo, Ph.D., Rosa Miceli, B.S.N., Lawrence Severt, M.D., Michelle Finnegan, M.P.H., and Joel M. Trugman, M.D., for the ADVANCE Study Group* N Engl J Med 2021;385:695-706

	MMD reduction	Responder rate (≥50%)
Placebo	2.5	29.0
10mg	3.7*	56*
30mg	3.9*	59*
60mg	4.2*	61*

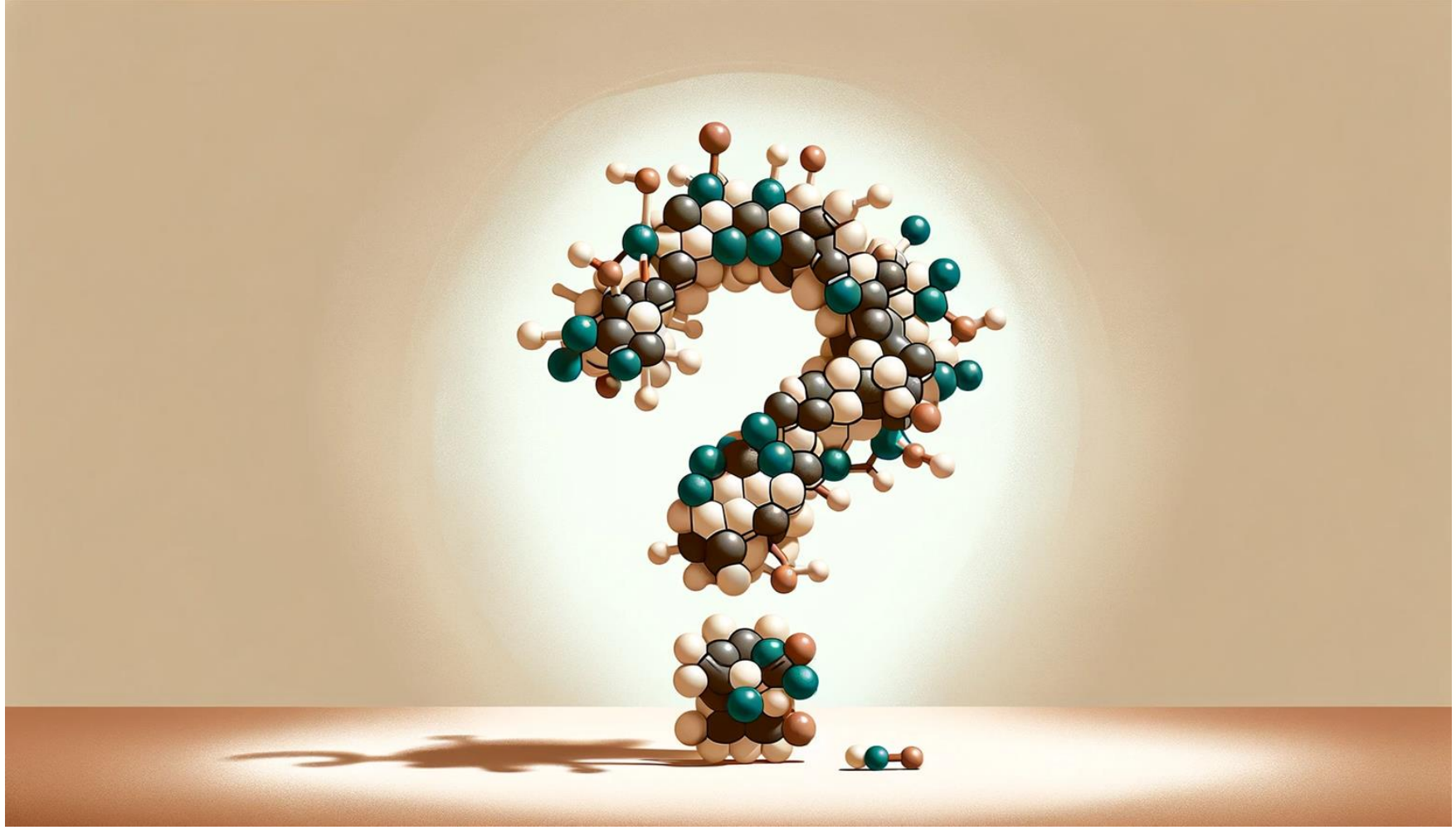
	Constipation (%)	Nausea (%)
Placebo	0.5	2
Atogepant	7-8	4-6

*(P<0.001)

All secondary endpoints met in 30/60mg dose groups;

No treatment-related SAEs
Discontinuations due to AEs were 2%-4% in atogepant groups, and 3% in placebo.

- Launch March 6, 2023
- Price matched to mAbs.
- PSP enrollment form
- Requires 2 oral preventative failures
- Rx: 10/30/60 mg PO once daily
- EM+CM
- EAP covered for EM and CM!



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What's New in the 2024 CHS Preventive Guidelines

New episodic migraine recommendations

- New agents have been added
- **CGRP agents have strong recommendation and moderate to high quality of evidence**

Recommended for use in episodic migraine		
Drug	**Recommendation strength**	**Quality of evidence**
Atogepant	Strong	Moderate
Eptinezumab	Strong	Moderate
Erenumab	Strong	High
Fremanezumab	Strong	Moderate
Galcanezumab	Strong	Moderate
Candesartan	Strong	Moderate
Topiramate	Weak	Moderate
Rimegepant	Weak	Moderate
Memantine	Weak	Moderate
Levetiracetam	Weak	Low
Enalapril	Weak	Very low
Melatonin	Weak	Very low

Medrea et al. *Canadian Journal of Neurological Sciences*. Published online 2024:1-23.

Previous recommendations EM

Previous recommendations for episodic migraine in effect from 2012		
Drug	**Recommendation strength**	**Quality of evidence**
Propranolol	Strong	High
Metoprolol	Strong	High
Amitriptyline	Strong	High
Nadolol	Strong	High
Butterbur	Strong	Moderate
Riboflavin	Strong	Moderate
Coenzyme Q10	Strong	Low
Magnesium citrate	Strong	Low
Divalproex	Weak	High
Flunarizine	Weak	HIgh
Pizotifen	Weak	High
Venlafaxine	Weak	Low
Verapamil	Weak	Low
Lisinopril	Weak	Low

Previous recommendations for episodic migraine in effect from 2012		
Drug	**Recommendation strength**	**Quality of evidence**
Not recommended for use in episodic migraine (DO NOT USE)		
Onabotulinum toxin type A	Strong	High
Feverfew	Strong	Moderate

These still are in effect!

Medrea et al. *Canadian Journal of Neurological Sciences*. Published online 2024:1-23.

New chronic migraine recommendations

- **All CGRP agents have strong recommendation, and high quality of evidence**

Recommended for use in chronic migraine		
Drug	**Recommendation strength**	**Quality of evidence**
Atogepant	Strong	High
Erenumab	Strong	High
Eptinezumab	Strong	High
Fremanezumab	Strong	High
Galcanezumab	Strong	High
OnabotulinumtoxinA	Strong	High
Propranolol	Strong	Moderate
Topiramate	Weak	Very low

Medrea et al. *Canadian Journal of Neurological Sciences*. Published online 2024:1-23.

New situations where agents are **NOT** recommended in EM

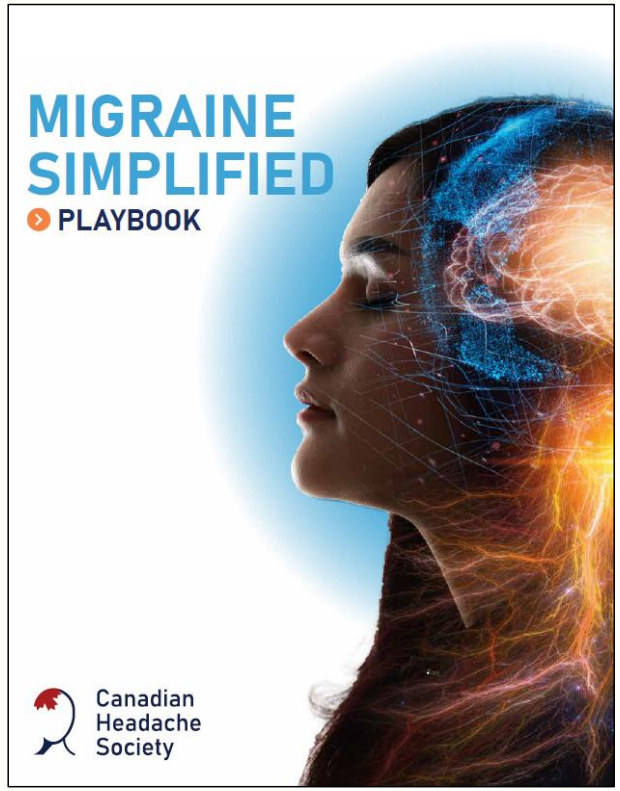
Not recommended for use in episodic migraine (DO NOT USE)		
Drug	**Recommendation strength**	**Quality of evidence**
Ginger	Strong	High
Gabapentin	Weak	Very low
Statin alone or add-on	Weak	Very low

Medrea et al. *Canadian Journal of Neurological Sciences*. Published online 2024:1-23.

Introducing a New Free Resource

Sections

- Referral to a Headache Specialist
- Acute Therapies
- Preventive Therapies
- Transitioning Back to Primary Care



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SPONSORS: Teva Canada Educational Grant

How to See a Migraine Patient in ***10 Minutes***

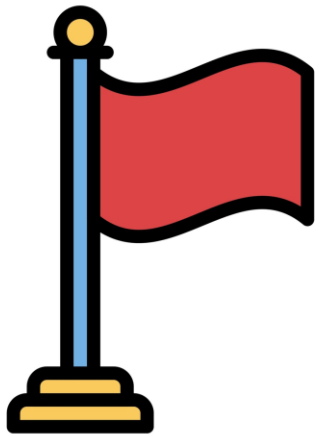
A practical, step-by-step approach

Your 10-Minute Roadmap

1. Rule out emergencies (1 minute)
2. Diagnose migraine quickly (2 minutes)
3. Start or optimize acute therapy (2 minutes)
4. Decide on preventive therapy (3 minutes)
5. Give follow-up plan & diary instructions (2 minutes)

Step 1 (Minute 1): Check for Red Flags (SNOOP6)

If ANY are present → Urgent imaging or ED.



- **S**ystemic symptoms (fever, weight loss) → MRI
- **N**eurologic deficits → MRI
- **O**nset peak <1 min (“thunderclap”) → ED
- **O**lder >50 → ESR/CRP + MRI
- **P**apilledema → Urgent neurology + MRI/MRV
- **P**ostural, **Previous**, **Precipitated by Valsalva**, **Pregnancy**, **Progression** → MRI or ED

✅ **If neurologic exam is normal and headache stable → NO imaging needed.**

Red Flags in Headache History. American Headache Society; Micieli A, Kingston W. An Approach to Identifying Headache Patients That Require Neuroimaging. Front Public Health. 2019;7;

Step 2 (Minutes 2–3): Diagnose Migraine Fast (The PIN Tool)

Ask 3 questions:

- **P**hotophobia: “Does light bother you?”
- **I**mpairment: “Have headaches limited you ≥1 day in last 3 months?”
- **N**ausea: “Do you feel sick to your stomach during headaches?”

≥2 positive = Migraine likely
Sensitivity 81%, PPV 93% (CHS Playbook)

✅ This replaces long ICHD-3 criteria in a primary care visit.

Lipton RB, et al. A self-administered screener for migraine in primary care. Neurology. 2003;61(3):375-382

Step 3 (Minutes 3–5): Start/Optimize Acute Therapy

Treat early (within 30 minutes). Avoid opioids.

Options

NSAIDs

- Naproxen 500 mg (repeat in 2–4h)
- Diclofenac powder 50 mg

Triptans

- Rizatriptan 10 mg (repeat in 2–4h)
- Sumatriptan 100 mg (oral), 20 mg nasal spray, or 6 mg SC

Gepants

- Rimegepant 75 mg ODT (once/24h)
- Ubrogepant 50–100 mg (repeat in 2–4h)

✅ Limit acute meds to <15 days/month total

✅ Triptans <10 days/month

✅ Gepants do not cause medication overuse headache

Step 4 (Minutes 5–8): Should You Start Prevention Today?

Start preventive therapy if:

- **≥4 headache days/month**, or
- **≥8 days/month even if acute meds work**, or
- Severe disability despite low frequency

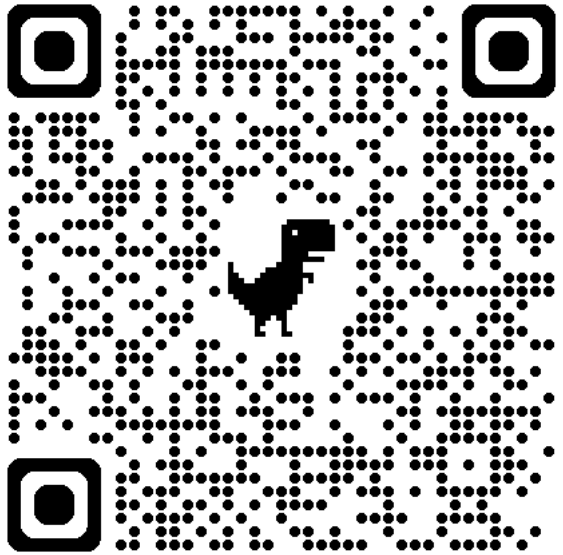
Fast First-Line Options

Episodic Migraine (<15 days/month)

- Candesartan 8–16 mg daily
- Amitriptyline 30–75 mg qHS

Chronic Migraine (≥15 days/month)

- Propranolol 20–80 mg BID
- Topiramate 25–100 mg qHS
- Consider CGRP mAbs if ≥2 oral preventives failed



✅ Trial each preventive at *target dose for 2–3 months.*

Step 5 (Minutes 8–10): Give the Plan & Follow-Up

1. Headache diary

- Recommend **Canadian Migraine Tracker**
- Track: days, meds used, severity, triggers

2. Acute plan

- “Use early. Repeat once in 2–4 hours if needed.”

3. Preventive plan

- Explain: aim is a **50% reduction**, not cure

4. Follow-up

- 6–8 weeks for adjustment
- Re-evaluate if worsening >8 weeks
- Immediately reassess if new red flags

AI-generated image created with OpenAI ChatGPT (2025).

When to Refer to a Headache Specialist

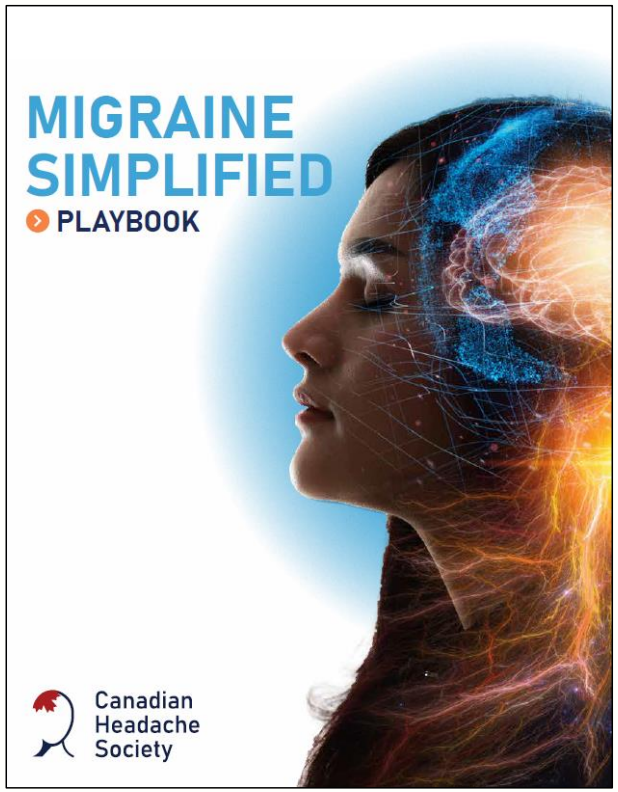
Refer if:

- Failed ≥2 preventive trials (adequate dose, ≥2 months each)
- Failed >2 triptans + >2 preventives
- Complex comorbidities or contraindications
- Persistent worsening despite treatment
- If wait times long → refer to general neurology

Red flags → urgent imaging or ED referral.

Thank You

Photo generated by DALL-E3



COVID-19: Sharing and Healing from Past Experiences of Caring for Patients during the Pandemic

Join our upcoming Community of Practice!

Wednesday, November 26
8:00 – 9:00 am

Physicians experienced trauma caring for patients during COVID-19, yet few family physicians have discussed this collectively.

Our panel will:
- Share their experiences and discuss coping strategies
- Highlight the need for ongoing support and exploration

Register

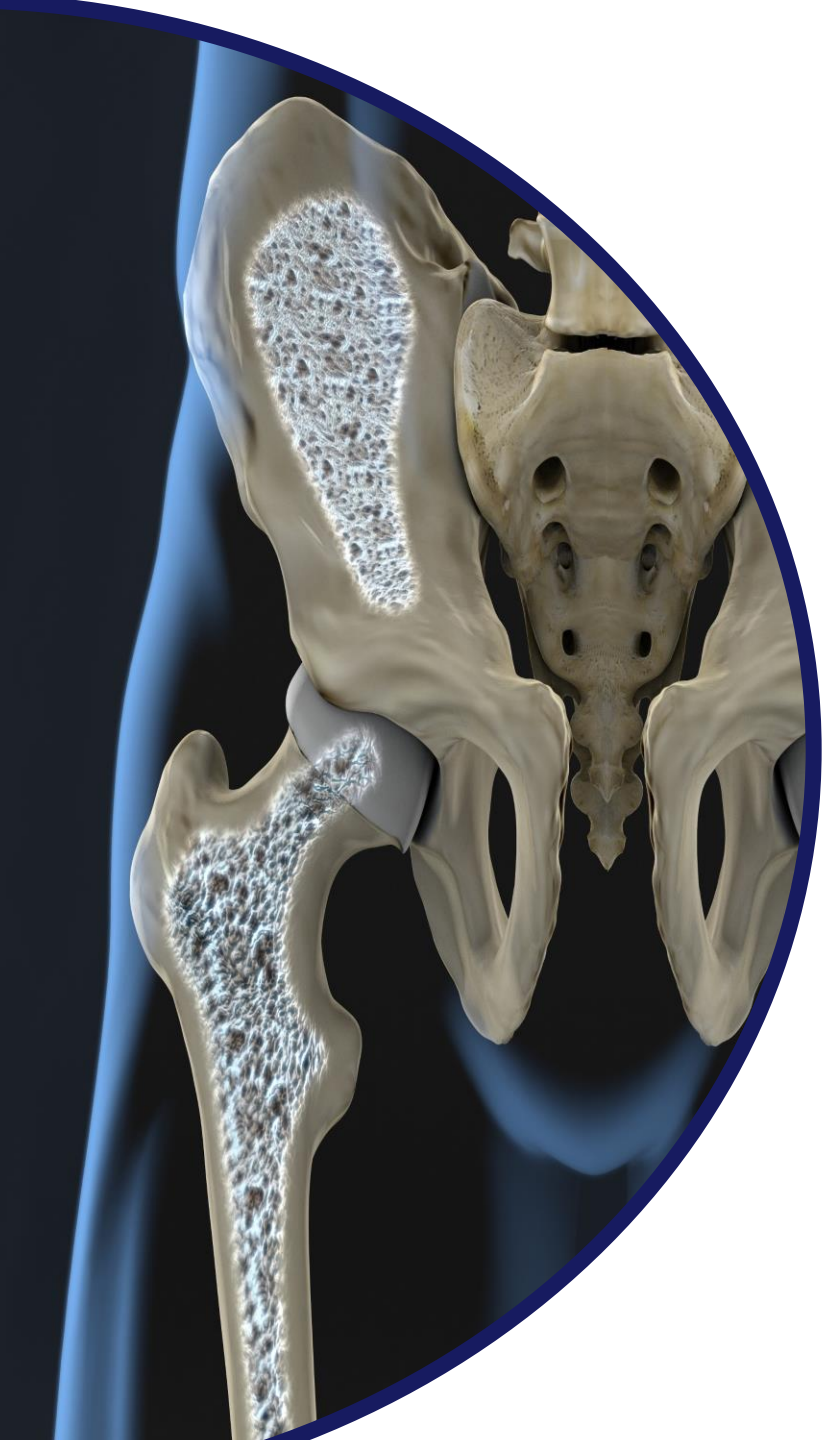
Health Equity CoP

In this session, we will explore how Family Physicians and Primary Care Providers can better support the health needs of newly arrived refugees in Canada. We will review global and Canadian refugee migration trends to understand the populations you may encounter, discuss appropriate screening tests and clinical considerations for newly arrived refugees and examine the benefits and limitations of the health insurance available to refugees.

November 27
12:00 – 1:00 pm

Topic: Supporting the Health of Newly Arrived Refugees in Primary Care

Register



Ontario College of Family Physicians

ONTARIO Osteoporosis Strategy

Osteoporosis and Fracture Prevention Workshop

What you'll gain:

- A **practical toolkit** with resources and video content to support you in your practice.
- **Expert insights** from facilitators sharing the latest updates from the 2023 clinical practice guideline.
- A **collaborative learning experience** designed specifically for family physicians.

December 3
12:00 – 3:00 pm

$195 + HST

Last chance to earn three Mainpro+ credits/h

Register

Scan to learn more

DFCM's First Five Years Community of Practice

Free, fun and full of answers to all those questions you never thought to ask during residency, this monthly online CPD series is about supporting early career physicians as they get started in their family medicine career!

Upcoming sessions:

From 7 – 8pm:

Jan 20, 2026: Work smarter, not harder: Managing your inbox and paperwork

Feb 24, 2026: Getting started with financial planning

Mar 24, 2026: Patient referrals: using eConsult, eReferral and SCOPE

Registration will open soon on the First Five Years CoP website

The First Five Years Community of Practice is a one-credit-per-hour Group Learning program that has been certified for up to a total of 9 Mainpro+ credits.

RECENT SESSIONS

July 18	**Infectious Disease and Retirement Planning for Physicians**	Dr. Zain Chagla Dr. Mark Soth
September 5	**Infectious Disease: Preparing for Fall & Important Vaccine Updates**	Dr. Daniel Warshafsky Dr. Allison McGeer
September 26	**Infectious Disease & Metabolic Associated Steatotic Liver Disease**	Dr. Daniel Warshafsky Dr. Hemant Shah
October 17	**Infectious Disease & Managing Nutrition**	Dr. Gerald Evans Dr. Mary Sco
October 31	**Infectious Disease & New Aneurysm Screening Program**	Dr. Daniel Warshafsky Dr. Varun Kapila

Past Webinars, Slides, Self-Learning & More Resources:
https://dfcm.utoronto.ca/past-changing-way-we-work-community-practice-sessions

UPCOMING SESSIONS

Month	Date
December 2025	December 5
January 2026	January 16

SAVE THE DATE

Registration links will be emailed to you closer to the date

Ontario College of Family Physicians
Thriving Family Physicians in a Healthy Ontario

Family & Community Medicine
UNIVERSITY OF TORONTO

Questions?

Webinar recording and curated Q&A will be posted soon.

Session slides will be available by the end of the day:
https://dfcm.utoronto.ca/past-changing-way-we-work-community-practice-sessions

Our next Community of Practice: December 5, 2025

Contact us: ocfpcme@ocfp.on.ca

The Changing the Way we Work Community of Practice for Ontario Family Physicians has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 32 Mainpro+ Certified Activity credits.

Post session survey will be emailed to you. Mainpro+ credits will be entered for you with the information you provided during registration.

Family & Community Medicine
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Ontario College of
Family Physicians
Thriving Family Physicians in a Healthy Ontario