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Migraine Treatment Update 2023

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Silberstein:
This is Dr. Stephen Silberstein from the Jefferson Headache Center, giving you an update on migraine treatment. This is an old advertisement, a cover of *Time* magazine, “Preventing Headaches: The Latest Research Offers New Hope for All of Us.’ And today, it's more pertinent than ever.

When should we consider prevention? When migraine interferes with the patient's daily routine, despite acute treatment, when the attacks occur more than once a week. This is the risk factor for daily headache or medication overuse headache, which I'll talk about, if the acute medicines don't work can't be used, have significant adverse events or overuse, patient preference. If you're a neurosurgeon, and you have one disabling migraine attack a month, you don't want to have that while you're cutting somebody's brain open. And then special circumstances such as hemiplegic migraine, basilar migraine, migraine with prolonged aura, and migrainous infarction.

It's important to realize that of all the migraine sufferers, 40% are eligible for prevention, and only about 13% are adequately getting it. Now let's look at migraine treatment adherence. What are the proportions of the patients’ adherence? At 6 months, 26%; at a year, 70%. These are the old oral treatments. Why? It doesn't work, side effects, better, cost, or other. So as I was mentioning, only about 20% of patients continue to take their medicine orally after a year.

Now there are different kinds of preventative medications. There are anticonvulsants, antidepressants, beta blockers, serotonin antagonists, onabotulinum toxin, ACE inhibitors, the new class of monoclonal antibodies, erenumab, fremanezumab, galcanezumab, eptinezumab, there’s the neutroceuticals, and the gepants.

What are the principles of preventative drug treatment? Start low and go slow. Not anymore. For the mAbs and the gepants, full stream ahead. We still need an adequate trial for 3 to 6 months. We need to avoid drug overuse and interfering drugs. We evaluate therapy. We use a calendar, and if patients are well controlled for 6 months, if they agree and we agree it's the right thing to do. And we avoid pregnancy and make sure you ascertain the use of birth control.

How do you decide what to use? What type of migraine? When you talk about the drug's efficacy, it's the scientific evidence and the clinical experience. What are the drug’s adverse events and safety? What are the comorbidities and coexisting diseases that affect your choice? What is patient preference? And use the safest, most effective medication with the fewest adverse events. Comorbidities are important. They impact treatment choice, stroke, angina, hypertension, bipolar, depression, epilepsy, fibromyalgia, vertigo, irritable bowel, peptic ulcer, delayed gastric emptying, and last but not least, allergies, asthma, and obesity, which makes migraine worse and harder to treat.

So what do we recommend? We used to say take one drug for both. No. Take the best. Take the best drug to treat each disorder, and

try to pick one drug it's the first-line option for multiple disorders. Do not treat migraine with a drug which is contraindicated for the other disorder, and not to use the drug for the other disorder that exacerbates migraine. Be aware of drug interactions and pay attention to women of childbearing potential.

Thank you.

Announcer:
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