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Two Lenses on Migraine: Managing Incomplete Acute Treatment Response

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Dr Fallon Schloemer and Dr Susan Hutchinson have received compensation from the US Medical Affairs Department of AbbVie Inc. to prepare and present the following information and are speaking on behalf of AbbVie.

And now, here's your host, Dr Schloemer.

Dr Schloemer:
This is ReachMD, and I am Dr Fallon Schloemer.

Even with multiple acute treatment options available for migraine, many patients continue to experience suboptimal outcomes.[1]

That's why, today, we're diving into incomplete response to acute treatment: what it is, why it matters, and what we can do to help.

I'm a neurologist and headache specialist, currently serving as the Medical Director for the AbbVie US Medical Affairs migraine team. I'll be sharing perspectives from a headache specialist standpoint, where we often see patients with difficult-to-treat migraine who can benefit from more detailed evaluation and follow-up.

I'm joined by my colleague, Dr Susan Hutchinson. Susan is a family medicine physician and a United Council for Neurologic Subspecialties, or UCNS-certified, headache specialist. She serves as the Director of Headache Medicine at Haven Headache and Migraine Center in Irvine, California. Susan, it's great to have this conversation with you.

Dr Hutchinson:
Thank you, Fallon. I'm glad we're talking about this. And while I also specialize in headache I'll be speaking more from my primary care lens—where migraine is one of many diseases we're managing.

Visits are often only 15 minutes, so reviewing a patient's migraine care in detail can be very challenging.

So the way we assess and manage treatment response can look a bit different from what you might see in specialty care. I'm really looking forward to exploring how those approaches come together in clinical practice.

Dr Schloemer:
As am I. And with that being said, Susan, let's jump right in. Given those potential differences in perspective, when we talk about incomplete response to migraine acute treatment, what does that look like for patients in practice?

Dr Hutchinson:

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That's a great question, and the reality is, terms like incomplete, insufficient, or inadequate response aren't defined the same way across guidelines, consensus statements, research, or even in day-to-day clinical practice.[2-4]

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Definitions of incomplete response should also extend beyond efficacy alone. For example, poor tolerability due to side effects, even if a medication is effective, can still represent a suboptimal outcome if a patient can't take it consistently.[2,4] Safety considerations, including cardiovascular risk, as well as contraindications, may also factor in into how we define whether a treatment is appropriate for a given patient.[4]

So from a primary care perspective,—where do I even begin? Because we're trying to weigh all of these factors within the time constraints of a typical visit.

Dr Schloemer:
I think that's exactly right. And even across guidelines or consensus statements—from the American Headache Society, the American Academy of Neurology, the American College of Physicians, and others—there isn't complete alignment in how treatment response is defined or assessed.[3-6]

So while they provide a helpful framework, they don't offer a single, consistent answer, and ultimately, care needs to be individualized for our patients.[3,4]

Headache specialists often turn to the American Headache Society Consensus Statement as a way to help define treatment goals. It highlights rapid and consistent freedom from pain and associated symptoms, especially the most bothersome symptom, without recurrence.[4]

But the goals go beyond pain relief. The AHS Consensus Statement also emphasizes restoration of function, minimal need for repeat dosing or rescue medications, optimal self-care with reduced subsequent use of healthcare resources, and minimal or no adverse events.[4]

So when we think about treatment response, we're really talking about a comprehensive outcome—helping patients return to normal function in a way that's safe, effective, and tolerable.[2,4]

So knowing all this, Susan, how do you assess incomplete response in a primary care setting?

Dr Hutchinson:
Well, I think there's often a gap between guideline targets and what patients are actually experiencing or expecting.

In primary care, assessment also depends on the context of the visit. We're often working within appointment time constraints, and migraine may not be the primary or only reason the patient is coming in, so it can be difficult to fully assess in that same visit. In those situations, I recommend scheduling a migraine-focused follow-up visit.

Once I have that space, I start by asking open-ended questions to understand the patient's overall treatment experience. I don't typically use questionnaires, cause I prefer to engage the patient in a meaningful dialogue. So I may start with, "How are you doing with your acute treatment?" or "What's working and what's not working with your acute treatment?"

From there, I may ask, "After taking your migraine medication, are you consistently migraine-free within two hours?" "Does the migraine go away and stay away for at least 24 hours?" "Are you experiencing any side effects from your medication?" and, "Do you need to repeat your medication or use a rescue medication?"

What has changed for me is looking for complete migraine freedom—ideally within one to two hours—not just headache relief. I want my patients to experience complete resolution of migraine symptoms, such as nausea and sensitivity to light and sound.[7]

I also use the "Ask–Tell–Ask" approach to guide those conversations: starting with open-ended questions, addressing potential strategies, and then checking back in to make sure the plan aligns with the patient and their treatment goals.[8,9]

And there's actually data to support this. Two American Migraine Communication Studies looked at how PCPs, neurologists, nurse practitioners, and physician assistants that interacted with patients with migraine. Unfortunately, they found that clinical communication was often physician-centered, and migraine-related impairment was addressed in only 10 percent of encounters. But after training in open-ended questions, this increased to about 90 percent of the 66 encounters that were studied.[8,9]

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Well, so when we take a more patient-centered approach, it creates space for patients to share how migraine is affecting their daily lives. And when I understand that impact more clearly, it becomes easier to adjust treatment in a way that's meaningful to them.

Now, what about you, Fallon? How is incomplete response assessed from the perspective of a headache specialist?

Dr Schloemer:
So, in specialty care, we often build on those same types of conversations, but we may also incorporate structured tools like the Migraine Treatment Optimization Questionnaire, or mTOQ-6.[2]

It's a six-question tool that looks at the key domains that research shows are most important for optimizing acute treatment: quick return to function, two-hour pain freedom, sustained 24-hour pain relief, tolerability, comfort making plans, and that sense of perceived control.[2]

What I appreciate about tools like this is that they shift the conversation from clinical outcomes to what really matters in a patient's day-to-day life. They may say their medication "works," but when I ask whether they can confidently plan their day, the answer is often no. And that's the disconnect resources like this help reveal.

Beyond that, I also try to get granular about a patient's experience. I'll ask questions like:

- "Does your treatment work consistently from one attack to the next?"
- "Is your treatment addressing your other migraine symptoms—like nausea, light, and sound sensitivity?"
- "Are you experiencing any side effects of your medication, and does this ever make you avoid taking it?"
- And, importantly, "What does a medication 'working' mean to you?"

Sometimes a patient's definition of success is just getting through the day, but we want to encourage them to aim higher than that. These types of questions help me pinpoint where the breakdown is happening. They also create an opportunity for shared decision-making, where we can validate their experience, reset expectations, and work together to find an approach that may help restore function and control.

So, with all that being said, let's think big-picture for a moment. Why is early recognition of incomplete response intervention so important for our patients with migraine?

Dr Hutchinson:
Well, this is where we really have to consider the downstream consequences of incomplete response to acute treatment.

First, there's the risk of medication overuse.[10] A web-based study called CaMEO-I was conducted across six countries from 2021-2022.[11] It found that, in patients taking migraine acute medications in the United States cohort, 25 percent met criteria for overuse. What's particularly notable is that of those with medication overuse, 66 percent scored very poor to poor on treatment optimization.[10] So we see a connection between inadequate acute response and medication overuse.

Beyond that, inadequate management of migraine attacks is associated with pain and disability, and is a risk factor for disease progression.[1,12]

And when patients experience repeated incomplete response, they may become less confident in their current treatment strategy, which can influence adherence.[4] I've seen some patients resign from prescription therapies altogether. Others may begin supplementing with over-the-counter medication or escalating to opioids or barbiturates.[13,14] So recognizing incomplete response early may help us intervene sooner and keep patients engaged in their care.

Dr Schloemer:
For those just tuning in, you're listening to ReachMD.

I'm Dr Fallon Schloemer, Medical Director for the AbbVie US Medical Affairs migraine team, and I'm speaking with Dr Susan Hutchinson about addressing incomplete acute treatment response in migraine and determining when therapeutic optimization is needed.

So, Susan, let's talk now about where we are with acute treatments for migraine.

We know that triptans are a therapeutic option and that the AHS Consensus Statement recommends a trial of at least two oral triptans before switching to a different medication class.[4]

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Knowing that, I'd like to explore how patients use triptans in real-world settings. What's important for clinicians to know?

Dr Hutchinson:
So the CaMEO-I study I mentioned earlier provides useful context. Among previous triptan users, about 59 percent had stopped at least one triptan and switched to another triptan at the time of the study. About 41 percent discontinued triptans entirely, and the most commonly cited reason for discontinuation was perceived lack of efficacy at 37 percent.[10]

And even among triptan users in the study, approximately 60 percent reported very poor to poor treatment optimization.[10]

Dr Schloemer:
Right. So that brings us back to the escalation patterns we sometimes see when patients aren't responding adequately to their acute treatments. In CaMEO-I, approximately half of triptan users reported using or keeping opioids or barbiturates on hand for their headaches, and among those, 80 percent reported use within the past 30 days.[14] But current guidelines and consensus statements recommend against the use of opioids for migraine.[4,7,15] So when incomplete acute treatment response goes unaddressed, we may see treatment patterns that shift toward therapies not aligned with guideline-based recommendations.

Susan, when you see, you know, your patients who are using opioids or barbiturates for migraine management, what really concerns you the most based on what we know from this data?

Dr Hutchinson:
Well Fallon, first I'll start by saying, that I don't prescribe opioids or barbiturates for migraine in my own practice because they're generally not recommended as first-line for migraine acute treatment.[4,7] At the same time, I do think it's important to acknowledge that although primary care providers aren't prescribing opioids anymore, they may still be prescribing butalbital.

What's also concerning is how opioid use is associated with worse overall outcomes. Going back to the CaMEO-I study, it showed that across multiple countries, patients using opioids had higher level of disability, lower migraine-specific quality-of-life scores, greater cognitive impairment, and greater use of healthcare resources compared to non-users.[16]

What's more, the data from the American Migraine Prevalence and Prevention study showed that use of opiates and barbiturates was associated with a higher degree of progression from episodic migraine to chronic migraine over time.[17]

And while these are observational data, the pattern is consistent between opioid use and disease burden.[16,17] Based on my clinical experience, once patients begin using opioids, these treatment patterns can be difficult to change, which is why optimizing acute treatment before escalation occurs is so important.

Dr Schloemer:
So with that in mind, let's talk about what treatment optimization actually looks like in practice. We really do have several levers we can pull.

We can switch within the same class—for example, trying a different triptan—or move to a different mechanism of action, such as a gepants or ergotamines.[4]

We can also think about selecting the right formulation to match the needs of the attack.[4]

And sometimes, it's simply about adjusting timing: making sure patients are treating early enough in the attack.[4,18]

Ultimately, the key is *not* to continue the same strategy if it's not providing reliable pain freedom and functional recovery, or if it's creating unnecessary burden due to tolerability.[2]

So, Susan, as we start to wrap up, how do you think we can better partner across primary and headache specialty care to optimize acute treatment for migraine?

Dr Hutchinson:
Well Fallon, that's such an important question, because it really starts with aligning on shared goals. First, we want treatments that are effective, safe and well-tolerated.2,4 We also want to avoid unnecessary escalation, particularly to treatments that carry greater risk, such as opioids and barbiturates.[4,16,17]

And importantly, we want to treat the patient with migraine, not just the migraine. Guidelines provide a helpful framework, but in practice we have to assess the individual patient. Each person's goals, their comorbidities, tolerability profile, and response patterns are different. Our role is to systematically evaluate treatment response, recognize when it's incomplete, and adjust thoughtfully.[2,4] When we

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individualize care in that way, we're better positioned to help patients achieve sustained pain relief, restored function, and greater control over their migraine.

Dr Schloemer:
Excellent. Thank you so much. Well, this truly has been a valuable discussion on recognizing and addressing incomplete response in migraine acute management. I want to thank my colleague, Dr Susan Hutchinson, for sharing her perspectives.

Susan, it was really great speaking with you today.

Dr Hutchinson:
And thank you, Fallon. This was a wonderful conversation.

Dr Schloemer:
And for those listening or watching, we'd like to hear from you. Please take a moment to complete the post-survey found on this program's page at ReachMD.com. For ReachMD, I'm Dr Fallon Schloemer. Thanks for joining us.

Announcer Close
This program was sponsored by AbbVie US Medical Affairs. If you missed any part of this discussion, visit Industry Features on ReachMD.com, where you can Be Part of the Knowledge.

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