Transcript Details
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A Migraine Patient Journey: A Case Study on Navigating Preventive Treatments With Dr Lawrence Newman

ReachMD Announcer
Welcome to ReachMD.

This medical industry feature, titled “A Migraine Patient Journey: A Case Study on Navigating Preventive Treatments With Dr Lawrence Newman,” is sponsored by Amgen. This program is based on a hypothetical patient case and is intended for healthcare providers.

Here’s your host, Dr Jennifer Caudle

Dr Caudle:
Coming to you from the ReachMD Studios in Fort Washington, Pennsylvania, I’m your host, Dr Jennifer Caudle. Joining me to discuss a patient case and how we can successfully and effectively navigate migraine management with preventive treatments is neurologist Dr Lawrence Newman. There are many preventive therapies available today, and it will be great to hear about Dr Newman’s experiences. Dr Newman is Board Certified in Neurology and Headache Medicine and has specialized in headache medicine for over 25 years. In fact, he was one of the first to do a headache medicine fellowship. He’s a Professor in the Department of Neurology at New York University’s Grossman School of Medicine and Director of the Headache Division at NYU Langone. Dr Newman, thank you so much for being here today.

Dr Newman:
It’s a pleasure to be here.

Dr Caudle:
Now, Dr Newman, today we’ll be focusing our conversation on a case study to help us better navigate the path to effective migraine treatment for our patients. The case study will be presented in two parts so we can get your insights at different stages of the patient’s journey.

So, without further ado: our case study patient is John Schultz, a 40-year-old male, who has occasionally experienced intense unilateral head pain, accompanied by nausea since his late 20s. When his headache frequency gradually increased and he stopped getting relief from over-the-counter medications, Mr Schultz began missing days of work and became unable to help with his kids at home. A neurologist diagnosed him with episodic migraine and prescribed an acute medication for his attacks. Over the next 2 months, his attacks persisted, and his migraine became more debilitating. One of his migraine attacks could last several days and he was experiencing attacks about 6 times a month, which translated into approximately 12 migraine days per month. So, Dr Newman, given Mr Schultz’s history and how he is presenting at this point in the case study, what would you do next?

Dr Newman:
It sounds like there’s a real need to improve Mr Schultz’s migraine management. His 12 migraine days a month are causing him significant disability that’s impacting his professional and home life. According to the American Headache Society recommendations, having 6 or more headache days a month, even without disability, is an indication to start oral preventive therapy. So, Mr Schultz and I would sit down and talk through how to better treat acute attacks and how to reduce the frequency of his attacks with a preventive therapy.

When starting a discussion on preventive therapy, I make sure to establish realistic expectations. While there’s no cure for migraine, we can hopefully reduce the frequency of migraine days each month.

Dr Caudle:
And after setting those expectations, what preventive options would you consider for Mr Schultz?

Dr Newman:
Well, we have several options and as much as we strive to get treatment right the first time, we don't have a way of knowing which therapy will be effective in any individual patient. Unfortunately, it's often a trial and error process. But the good news is that there've been recent developments in this field, and we have more treatments available to us now.

So, I explain all the preventive treatment options to my patients. We have oral preventive drugs and as of recent years, we also have newer injectable or intravenous monoclonal antibodies that target the calcitonin gene-related peptide, CGRP, pathway. Based on American Headache Society recommendations, we'll try the oral preventive medications first and hopefully they'll work, but if they don't, then we can try one of the anti-CGRP monoclonal antibodies.

Dr Caudle:
Thank you for that insight, Dr Newman. And for those of you who are just tuning in, you're listening to ReachMD. I'm your host, Dr Jennifer Caudle and here with me, today, is neurologist Dr Lawrence Newman, who's sharing his perspective on how we can navigate migraine management with preventive treatments through the lens of a patient case.

So, Dr Newman, let's dive into the second part of our case study. Mr Schultz went back to his neurologist and was started on oral preventive medications. First he was prescribed a beta blocker and was titrated up to the recommended dose, but he couldn't tolerate the side effects. His neurologist then switched him to an anti-convulsant, titrated to the recommended dose, and he stayed on this treatment dose for 2 months. Since then, his migraine attacks have decreased to about 4 a month, so about 8 monthly migraine days. This is 4 fewer days per month, but migraine is still affecting his everyday life dramatically. Now, Dr Newman, I know you mentioned trial and error before. How do patients typically react to this process?

Dr Newman:
Well, cycling through medications can be a long process. It can be many months of optimizing treatment, which can be frustrating to the patient. It can also be frustrating to me, as the healthcare provider. In my experience, failing to respond to medications or experiencing side effects to them can cause the patient to stop coming for follow-up visits, as they get fed up and think that this is going to be their lot in life. So even though it's trial and error, we have to make sure the process is as efficient and effective as possible for our patients.

I have patients who have learned to live with their migraine burden and if asked, they say they're "fine", but I like to really assess what patients mean when they say they're fine. I think we need to encourage patients not to settle for fine, because there are a lot of options to try. I think it's imperative that if a clinician determines a preventive treatment is failing a patient, they discuss changing the migraine treatment plan. Imagine living with the migraine burden of your patient for the rest of your life. Unfortunately, I will see new patients who have been on a drug for 5 years. They started with 15 migraine days a month, they still have 15 migraine days a month and their doctor never changed the medication.

So, I want to encourage my fellow healthcare providers in the same way that I encourage my patients to not get discouraged by the trial-and-error process. With the recent approvals of anti-CGRP monoclonal antibody therapies, we now have more options available.

Dr Caudle:
Well, you know, that's a really great call to action and sentiment that you add, Dr Newman. You know, if we go back to our patient case, would you recommend that Mr Schultz change his preventive therapy at this point?

Dr Newman:
I would. It's great that he has seen a reduction in monthly migraine days, but he's continuing to be affected by migraine. Now that 2 medications, according to AHS guidance, have failed to adequately control his migraine, I'd talk with Mr Schultz about other options, such as the anti-CGRP monoclonal antibodies, which were specifically designed to target molecular pathways involved in migraine pathophysiology. I'd talk with Mr Schultz about the risks and benefits of these medications and while I refer to them as 'newer', I've had a lot of experience with them.

Dr Caudle:
Can you expand on how these anti-CGRP monoclonal antibodies are given?

Dr Newman:
As monoclonal antibodies, they're given by injection or intravenous infusion. Once we determine which anti-CGRP monoclonal antibody to use, I walk the patient through what to expect and dosing and administration information. We also give our patients the web address of the product they're using where they can find support information such as access program information, instructions and overview videos

on how to administer the product. We tell them just to call us if you don't find the information you need, and we'll walk you through it.

Dr Caudle:
And if we return to our patient case one last time, Dr Newman, the anti-CGRP monoclonal antibody would be the third preventive treatment Mr Schultz receives. How would you help him or other patients who may feel discouraged?

Dr Newman:
As I mentioned earlier, it's important to set realistic expectations. Patients might assume that within a couple of weeks they're going to be migraine-free and if that doesn't happen, they can give up on the treatment. Though anti-CGRP monoclonal antibody therapies can start working earlier, treatment benefits can sometimes take up to 3 months. Therefore, it's recommended by the American Headache Society to allow at least 3 months for the monthly medications and 6 months for the quarterly medications when patients are trying these therapies.

I have chronic migraine and went many years without having effective treatment until I finally found something that worked. I tell my patients I know exactly what their journey is because it was my journey. I let them know I'll be with them every step of the way and I tell them, "You'll give up on me before I give up on you." Success is more than just a reduction in migraine days, it's making sure patients have an effective treatment plan that minimizes the impact of migraine on their everyday lives.

Dr Caudle:
Thank you so much for sharing that with us, Dr Newman. That's an excellent way for us to close today's program and I'd like to thank you, Dr Newman, for joining me to share your insights. It was great speaking with you today.

Dr Newman:
And you as well. Thanks for having me.

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