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Expert Insights on Migraine Preventive Treatments With Dr Stephanie Nahas

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Welcome to ReachMD. This medical industry feature, titled “Expert Insights on Migraine Preventive Treatments with Dr Stephanie Nahas,” is sponsored by Amgen. Presenting is Dr Stephanie Nahas.

Dr. Nahas:

Migraine is more than just a headache; it’s a neurobiologic disease that affects the individual, their personal network and society. The pain, suffering and economic impact, combined, can pose a substantial burden.

Hi, I’m Dr. Stephanie Nahas and I’m a neurologist and headache specialist at Thomas Jefferson University in Philadelphia, Pennsylvania, where I’m the director of the Headache Medicine Fellowship program. Not only do I take care of people with migraine, I also live with migraine, myself, and have many friends and family members with the disease, which makes this personal. Today, I’ll be discussing my key considerations for managing patients with preventive migraine therapies.

I find that something that we don’t talk about enough, as clinicians, is how we can impact someone’s life with an effective migraine management plan. In reality, our successful management of migraine is so important to the lives of our patients. Migraine may affect not just the individual but also so many others in their network who depend on them, including, their family, friends and employer. The impact of migraine and its ramifications can be substantial.

For families, it can get very frustrating. I often hear that people with migraine may consider having fewer children because of their disease or may believe they would be better parents if they did not have migraine. I’ve also heard people with migraine say they’ve lost friendships because their friends blame them, not their migraine, for the impact to their relationship.

People with migraine experience disruption to their work lives. They may miss days of work and experience migraine symptoms while working, including pain, nausea, sensitivities to light and sound and, for some, impaired vision, among other symptoms. Imagine if you had migraine and experienced an attack in the middle of seeing patients; what would you do? How would it affect your ability to do your job?

As someone who cares so much about migraine, I want my fellow physicians to think about how this disease can impact a person’s everyday life. People with migraine can worry about when the next attack is going to happen. They may think, “Will I be prepared to deal with it? Will it strike at the worst possible time?”. Maybe they started having migraine attacks in high school. Maybe they gave up their goal of becoming a lawyer, doctor, public servant, you name it, because they couldn’t be relied upon all the time. They think, “How can I pursue my dream when I have migraine always striking me down?”. This really highlights how important migraine management is to our patients.

There are a few different approaches to managing migraine, including lifestyle and behavioral modifications, as well as medical therapies. Acute medications to treat the migraine attacks themselves, and when it’s appropriate, preventive therapies are used with the goal of decreasing the frequency of migraine days. Migraine is a complex disease and decisions about starting therapies are different for each person. Factors like the frequency of migraine days and the impact of migraine help me identify potential candidates for preventive therapy.

When my patient and I decide it's appropriate for them to start preventive treatment, we actually have no reliable predictors to help select the best therapy. We aren't, yet, at the point of individualized medicine for migraine, so a trial-and-error process is necessary. It's all about "try and try again" until we reach the response we're looking for. If a treatment fails my patient, that's not the end of the story; we can try another medication. The good news is that the migraine treatment landscape has changed over the past three years, particularly for preventive therapies and now we have even more options available. With the latest therapies, I think we, as physicians, will need to evolve our treatment approaches.

Let's discuss the tried and tested preventive treatments: the oral preventive therapies. Several oral preventive treatments are available and used as first-line therapies, such as anti-epileptic drugs and beta blockers. The American Headache Society recommends starting oral preventive medication at a low dose and titrating slowly until the desired response is achieved, adverse events become intolerable, or the dose limit is reached. If there is no response after a trial of eight weeks, at a target or a usual effective dose, switching preventive treatments is, then, appropriate.

If two oral preventive therapies are unsuccessful for a patient, a third oral preventive may be an option, but, according to American Headache Society guidance, another treatment class can also be considered. Monoclonal antibodies that target the calcitonin gene-related peptide, CGRP, and its pathway. What I find most exciting about these treatments is that, by targeting this system, they address an important aspect of migraine pathophysiology. As monoclonal antibodies, they are administered through subcutaneous injection or intravenous infusion.

I'd like to take a moment, here, to share some of my personal experience with using anti-CGRP monoclonal antibody therapies, which we will call "mAbs" for short. As with all preventive medications, patient preference is important. We have solid numbers for reduction in monthly migraine days for this class, so if my patient and I are discussing starting one and they're unsure, I like to take a step back and ask them, "What would your life be like with fewer migraine days?". When I'm starting a patient on an anti-CGRP mAb, setting realistic goals and expectations is important. An appropriate trial period for this class is a minimum of three months for those administered monthly and six months for those administered quarterly, according to AHS. Sometimes, I think we don't give these therapies enough time to work before we change course. To make sure patients don't get discouraged, they may need more education and a little pep talk. Some can see improvement earlier, but it may take more time to find out if it's a good match.

Here's another thing to consider when you're making decisions about starting, maintaining and switching preventive migraine therapies. I want to encourage you to do this thought exercise. How do you know your patient is fine with their current migraine regimen? How did you ascertain that? You asked them how they're doing, and they said, "Fine"? Patients may say they are fine, just because they are used to living with the burden of migraine and may not see the potential for improvement. I think it's important to ask questions that really assess whether medications are actually working for them.

Remember, treating migraine takes time, you have to practice at it and it's not easy, but keep in mind how good it makes you feel to take away even one migraine day and to see your patient's smile of gratitude. Reflect on these successes and let them fuel both you and your patients. I'm Dr. Stephanie Nahas and thank you for joining me.

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