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Treatment Considerations for Managing Migraine

Announcer:
Welcome to ReachMD.

This medical industry feature, featuring “Treatment Considerations for Managing Migraine”, is sponsored by Amgen. This program is intended for healthcare professionals.

Your host is Dr. Charles Turck.

Dr. Turck:
Managing migraine can be a complex responsibility for clinicians, calling for both an accurate and timely diagnosis, and appropriate treatment recommendations in order to help each patient the best that we can.

On today’s program, we’ll hear from a patient about her treatment experience with migraine and gain additional insights from a specialist about best practices in managing patients with this diagnosis.

This is ReachMD, and I’m Dr. Charles Turck.

Joining me today are Dr. Susan Hutchinson and Ms. Alexandria Srbinovski. Dr. Hutchinson is a headache specialist and board-certified family practice physician at Orange County Migraine & Headache Center in Irvine, California. Dr. Hutchinson, thanks for being here today.

Dr. Hutchinson:
It's a pleasure. Thank you for inviting me.

Dr. Turck:
And a special welcome back to Alexandria, who has been sharing her migraine journey with us throughout these programs. Alexandria is a migraine patient and advocate who is increasing awareness of the impact of migraine among the general public and health professions. Alexandria, welcome to you.

Alexandria:
Thank you so much for having me today. I'm so excited to be working with you guys and share my journey with you.

Dr. Turck:
Alexandria, let’s kick off today’s program with your experience of migraine. Can you share some of the symptoms you often face, and how you’ve tried to manage them yourself?

Alexandria:
Sure. So, when I have a migraine, some of the symptoms that I often experience are dizziness, aura, vomiting, sharp pain on the side of my head, sound and light sensitivity, and for me, the most bothersome of these symptoms are the sounds and lights. For example, when I go into a store, sometimes the regular sounds and lights in there that most people don’t notice become overwhelming for me and can make the whole experience of going to the store, shopping, and interacting with people worse. I’ve looked into a lot of options to help reduce the symptoms that I’d mentioned earlier including the headache pain, nausea, and vomiting; I’ve tried everything from holistic and chiropractic treatments to acupuncture to natural and herbal supplements, and over-the-counter medications. But none of these options have worked for me, and when my

symptoms get really bad, I end up staying at home, in bed with the lights off, and an ice pack on my head.

Dr. Turck:
Thanks for sharing that, Alexandria. And based on experiences of migraine such as what you described, I want to turn to Dr. Hutchinson for some additional background on how migraine is diagnosed clinically, and the different ways it can impact our patients. Dr. Hutchinson, what can you tell us?

Dr. Hutchinson:
Well first, I want to stress that experiences with migraine, such as what Alexandria just shared, can be devastatingly disruptive to a patient's life, and that's why it's so important to me that patients get diagnosed quickly and accurately.

Based on IHS guidelines, to receive a migraine diagnosis, patients need to have experienced at least five headache attacks meeting certain criteria such as duration between 4 and 72 hours, headache characteristics like unilateral location, pulsating quality, moderate to severe pain intensity, and avoidance of routine activities, and non-headache symptoms such as nausea and/or vomiting, or sensitivities to light and sound.[1]

Migraine is one of the most burdensome neurological diseases[16] we manage because it's multifaceted and affects patients in so many ways.

About a third of patients experience migraine on 4 or more days of the month,[2] and just like in Alexandria's shared experience with migraine, upwards of half of patients report severe impairment or require bed rest.[3]

And clearly these kinds of symptoms and impairments can significantly disrupt everyday activities regularly, which carries the potential to impact personal relationships and family activities for migraine patients.[3]

But we also need to account for the burden of migraine beyond direct impairments themselves, such as feelings of stigmatization patients can face from others who don't experience migraine headaches,[4] or the comorbidities that may be associated with this disease.[5] And of course, everything we're talking about here can have broader implications for society as a whole in terms of direct healthcare costs and indirect costs like missed workdays for patients.[6]

Dr. Turck:
Well I think these perspectives you both shared provide a strong foundation for us to shift to treatment considerations for migraine. But Dr. Hutchinson, staying with you for a moment, I assume these burdens you talked about influence patient management as well. So what are some of the treatment challenges we need to be aware of?

Dr. Hutchinson:
Yes, there are definitely some ongoing challenges in migraine management for us.

First, like we were talking about before, getting an accurate diagnosis is such an important part of putting patients on effective treatment paths, but as we learned from the American Migraine Prevalence and Prevention Study of almost 19,000 people, 44 percent of study respondents who met the ICHD-2 criteria for migraine were never actually diagnosed with this condition.[7]

And we know that part of this issue may be rooted in the complexity of properly identifying migraine based on overlapping symptoms with other headache disorders.[1]

But beyond the diagnostic challenges, there are treatment challenges as well, such as with preventive treatment. For example, there's data to support that preventive treatments are being underutilized, with only about a third of patients who qualify for preventive treatments actually receiving them.[8]

And this may speak to a broader issue that, despite having current guidelines recommending individualized treatment approaches,[9] many patients have reported that they're not actually receiving adequate treatment and follow-up care.[9] So, taken together, these are all important factors that make migraine management so challenging.

Dr. Turck:
You mentioned the underutilization of preventive treatments in particular, but just to clarify, how do you look at migraine treatments on the whole?

Dr. Hutchinson:
So, there are two primary ways to treat migraine, and depending on the frequency of migraine attacks, both strategies may be needed to establish an effective treatment plan for patients.[10]

The first is to provide acute treatments to stop the migraine attack and provide more immediate symptom relief.[10] But while these therapies may be suitable for many patients, overuse of these treatments may lead to increased risk of developing medication-overuse headache.[11] Adverse events can include tolerability issues.

The other strategy is to incorporate preventive treatment options, which is useful for patients experiencing moderate to severe and/or frequent headaches.[11] These therapies are intended to reduce migraine attack frequency, duration, and severity.[11] However, these are often associated with patient adherence issues.[11] Some side effects may include depression, cognitive dysfunction, somnolence, constipation, and weight gain.[17]

Dr. Turck:
And what classes of treatment are currently recommended for acute versus preventive migraine therapy, Dr. Hutchinson?

Dr. Hutchinson:
There are several options available depending on the frequency and severity of migraine.

Among acute treatments that help patients achieve symptom relief and restore their ability to function, the AAN and AHS guidelines recommend use of migraine-specific medications such as triptans, ergotamines,[11] ditans, and gepants.[11] The guidelines also recommend use of neuromodulation devices[11] as well as general pain medications were prescribed such as NSAIDs and analgesics.[11] The AHS guidelines recommend to avoid the use of narcotics and barbiturates for acute migraine treatment.[12]

For preventive treatment options, where the goal is to reduce attack frequency and improve everyday functioning for patients, the AAN and AHS guidelines recommend use of anticonvulsants, beta-blockers,[11] triptans, ARBs, and CGRP-pathway targeting monoclonal antibodies, which have established efficacy.[11] Gepants have also recently been FDA approved for preventive treatment, so we may see this treatment option show up in updated guidelines in the future.[11] Certain neurotoxins like botulinum have been recommended as preventives for chronic migraine, specifically, but not for less frequent episodic migraine.[11]

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

I'm Dr. Charles Turck, and today I'm speaking with Ms. Alexandria Srbinovski and Dr. Susan Hutchinson about experiences and best practices in migraine management.

Alexandria, let's come back to your story as a patient with migraine and how you were treated for it. Can you tell us about your treatment journey so far?

Alexandria:
I actually had to go to the ER for my first severe episode, and I was given several medications to treat the migraine acutely, but they didn't work. So I went to see my PCP and was given both over-the-counter medicines and prescription drugs, but these didn't turn out to be effective for me, either, unfortunately. After that, I was able to see a headache specialist who had me try other treatments, but I found myself needing more relief for my severe episodes.

Dr. Turck:
That's such a difficult path to navigate, Alexandria, but I'll be interested to hear how things continued from there and led you to where you're at now. Before we cover that, though, I want to check in with Dr. Hutchinson. When you hear an experience with migraine like this, what are your preferred next steps for patients like Alexandria?

Dr. Hutchinson:
Well first I'd openly acknowledge this difficult journey that Alexandria has been on, and she's not alone, unfortunately.

I do see many patients like her who come to my practice after experiencing several migraine episodes without much relief from treatments to date. So, when I consider treatment plans moving forward, I like to begin with the end in mind.

My goal for someone like Alexandria would be to create an individualized management plan prioritizing important factors for her such as the severity and frequency of her symptoms, any comorbidities she might be dealing with, the medications she's currently taking, and her treatment preferences just to name a few.[11] We would also establish realistic expectations about her next treatment course by aligning on how we define success, such as when initiating migraine preventive treatments.[11] In those cases, I come back to the AHS guidelines which define success several ways, such as achieving a 50 percent reduction in the frequency of days with headache or migraine, or alternatively a significant decrease in attack duration and/or severity, both of which we would set by the patient's

standard.[11] But in any goal-setting encounter, I'd be open and honest that we might need to experience some trial and error together first before finding an optimal treatment.[11]

Dr. Turck:
Thanks, Dr. Hutchinson. Alexandria, circling back to you, can you share how your treatment course evolved after connecting with your headache specialist about needing relief for your frequent migraine episodes?

Alexandria:
Sure. I'd been on oral medications for about 4 years before my headache specialist and I connected on finding more relief. He had me try an injectable preventive medication, which has given me some relief in reducing the number of days per month that I deal with migraine. And just like Dr. Hutchinson said, this was an important measure between me and my doctor for getting relief. But I still live with migraine. Things are better than they were, but migraine is a part of my life.

Dr. Turck:
I appreciate that honest take on where you're currently at, Alexandria. And Dr. Hutchinson, drawing from that experience, how would you assess whether or not this preventive treatment Alexandria started was proving effective against migraine?

Dr. Hutchinson:
Well the most commendable step up front was when Alexandria let her headache specialist know about the need for more relief, which set everything in motion for her. And from there, it's our duty to assess the effectiveness of next treatments as best we can.

We can have patients keep a headache diary where they document their symptoms in real-time.[13] The diary is simple to use, and patients can do this digitally or on paper to document the frequency, intensity, duration, and other associated features of their headaches.

We can also use various validated patient-reported outcome, or PRO tools, such as the Migraine Disability Assessment test, more commonly referred to as MIDAS, which asks patients to answer five questions on migraine disability pertaining to headaches experienced over the last three months.[13]

There's also the Headache Impact Test, or HIT-6, which is a six-item questionnaire that assesses not just the severity of the headaches, but also how that impacts daily activities.[13]

Another PRO tool available is the Migraine-specific Quality of Life Questionnaire, or MSQ, which measures the impact of migraine along a few key parameters over the last four weeks, such as role prevention and emotional function.[13]

Dr. Turck:
Dr. Hutchinson, before we close, I'd like to get your thoughts on where other healthcare providers such PCPs, NPs, PAs, and others fit into the care models for migraine today. We heard about Alexandria's progression from the ERs to her PCP and over again to a headache specialist, but how can these and other providers work more collaboratively to incorporate a multidisciplinary approach to migraine treatment?

Dr. Hutchinson:
You're correct, given that clinicians such as PCPs, NPs, and PAs see just as many migraine patients as I do, if not more, I think it's so important to foster more collaborations and interconnections between multidisciplinary team members for patients like Alexandria.

The goal, as always, is to reduce headache days and disabilities for these patients, and the more integrated and holistic our care model, the more we might be able to get there together.[8]

Remember that patients with migraine may already be meeting with specialists and non-specialists alike on their care journey, from emergency physicians to PCPs to NPs and PAs to neurologists.[14] PCPs in particular have a critical role in helping make a timely and accurate diagnosis and gathering those important details of the patient's treatment history such as which medications worked and which ones didn't, and this would also include OTC medications and herbal supplements. Having all of this vital information can help to make a more informed decision regarding treatment.

Headache specialists are often then called upon when patients have more severe migraine symptoms, disabilities, or comorbidities.[15] But these headache specialists rely on open channels of communication to manage their patients better, and that's where incorporating a multidisciplinary approach may be especially beneficial for enhancing patient communications and keeping the line open to treatment decisions in the patient's best interests.

Dr. Turck:

These have been such important insights to take in from you both on ways we can improve management approaches for migraine patients.

I want to thank my two guests for sharing their respective experiences and takeaways on treatment decisions in migraine management. Alexandria, Dr. Hutchinson, it was great speaking with you both today.

Dr. Hutchinson:
Thank you for having me today.

Alexandria:
Thank you so much for having me. I really appreciate you guys taking the time out to talk to me about my journey.

Announcer:
This program was sponsored by Amgen. If you missed any part of this discussion, visit ReachMD.com/industry-feature. This is ReachMD. Be Part of the Knowledge.

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