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TRANSCRIPT

Transcript Details
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https://reachmd.com/programs/rethinkingmigraine/overcoming-barriers-to-migraine-prevention/9972/

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Overcoming Barriers to Migraine Prevention

Announcer:
This is ReachMD. Welcome to this special series, Rethinking Migraine, sponsored by Lilly.

On this episode, titled Stopping Migraine in its tracks: How to address Barriers to treatment, we will hear from Dr. Stephanie Nahas, The Director of the Headache Medicine Fellowship Program at the Jefferson Headache Center in Philadelphia.

Dr. Nahas:
It's estimated that nearly half of patients who have migraine would qualify for preventive treatment, but only a small fraction of those are even offered it. And when they are offered it, adherence to that treatment is surprisingly low, shockingly low. Again, probably half or less of patients adhere strictly to the recommendation of taking preventive medication on a daily basis for two to three months to reduce the burden of migraine over time. So it's important when recommending the treatment of choice that counseling is undertaken to fully educate the patient as to expectations, that there is a titration phase; there may be side effects which slow down the titration phase, but the goal is to get to the appropriate dose and to maintain it for the appropriate period of time. Only then will a patient know whether the medication is making a difference, and keeping calendars to track the frequency and impact of migraine attacks and acute medication use can also be quite useful for both the patient and the provider, to judge whether that preventive medication is working well enough for that individual. But these medications, as I said, come with side effects. And that is one of the major reasons that patients will stop taking it. Inefficacy is another. Oftentimes it's just a trial-and-error choice of a preventive

therapy which can be frustrating, knowing that it may take two to three months to see results, and then when no results are seen, you have to start all over again with a new preventive medication. So forming that therapeutic alliance and that understanding of realistic expectations of what may or may not occur is very important. Cost is another factor. Some patients won't even start a preventive medication if it is too costly, or if they do start it and it works but it's too costly to maintain, that is a major disappointment, and it may dissuade a patient from even wanting to try another option again. Because once one gets better, and then gets worse again, it can be quite devastating.

So, familiarize yourselves with the ones that come with the greatest strength of evidence and the highest recommendations. The American Academy of Neurology and the American Headache Society have both put forth guidelines for preventive and acute treatment for migraine. They're readily available, and it would behoove any practitioner to familiarize themselves with those treatments which come with a level A and level B recommendation, meaning first-line and second-line.

Announcer:
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