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American Headache Society Updates on Diagnosing and Treating Migraine

Announcer:
You're listening to *Neurofrontiers* on ReachMD. Here's your host, Dr. Charles Turck.

Dr. Turck:

Welcome to *NeuroFrontiers* on ReachMD. I'm Dr. Charles Turck, and joining me to review the latest American Headache Society guideline updates on migraine treatment is Dr. Jessica Ailani. She's a Clinical Professor of Neurology at MedStar's Georgetown University Hospital and the Director of the MedStar Georgetown Headache Center. Dr. Ailani, thanks for being here today.

Dr. Ailani:
Thank you so much for having me.

Dr. Turck:
So Dr. Ailani, let's do some level setting before we jump into the guidelines. Let's talk briefly about diagnosis. What are the most important clinical clues that help you distinguish migraine from other headache disorders?

Dr. Ailani:
So migraine is a headache disorder that comes with a lot of baggage. I like to tell my patients it comes with a number of associated symptoms, and that's really what we're looking for when we're making the diagnosis of migraine. We know the pain has to be moderate to severe. The head pain usually causes a person to stop physical activity. So we'll ask about when you're having the head pain; are you having to rest or stop movement, or does it get worse? Then the other things we're really looking for are the associated symptoms of nausea or vomiting and light and sound sensitivity.

And I find that patients don't always understand these questions, so I like to rephrase them in a way that might make it easier for them to respond to. Like, when you're having this type of headache, do you find that eating would make you feel worse? Do you find that eating upsets your stomach? Do you find the smell of food makes you kind of queasy? And then looking at light and sound sensitivity, I might ask the patient, in their ideal world and their ideal setting, when they're having a headache like this, what do they want to do? And you often hear them say, 'Well, I'd love to be in my bedroom with all the shades drawn. It's really dark. I make it cold, and I really don't want anyone around me.' If they're still struggling to find the right words, I ask them, if the lights are on and it's really bright and you're having this type of headache, how does it make you feel? And if it's really loud and noisy, and maybe your children are around shouting and making noise, or your co-workers are talking to you, do you find that that noise makes the pain worse? So rephrasing the questions are really important. But those are the associated symptoms that we look for in addition to head pain to make the diagnosis of migraine.

Dr. Turck:
Now, we've seen more and more clinicians consider preventive treatment earlier in the care journey, especially as new therapies become available. So what's driving that trend, and how is it changing the way we manage migraine?

Dr. Ailani:
Well, my hope is the trend is being driven by an increase in education, both to the patient population and to clinicians as well. We're really trying to reach all primary care providers and educate on the importance of understanding migraine, along with making a diagnosis but starting preventive treatment. In the same way, we're trying to reach patients and talk about disability: how much migraine impacts their day-to-day and how when you have an attack, the average person with migraine is missing two to three days a month of life. And

when you add that up over time, that's several years less life that you're living. And I think when patients hear that, and when clinicians understand that, there's really a move to start preventive treatment early so that patients can have a better quality of life.

And when we talk about treatments, I think the other big driver of prevention right now is that we have migraine-specific treatments that come with better efficacy and less side effects than some of our traditional oral treatments that have been available in the past. And I think that really helps people feel more comfortable starting a treatment knowing that it's really targeted to treat the disease that they have.

Dr. Turck:
For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Jessica Ailani about diagnosing and treating patients who suffer from migraines.

So Dr. Ailani, with that context in mind, let's dive into the American Headache Society's guidelines, which recommend calcitonin gene-related peptide, or CGRP, targeted monoclonal antibodies as first-line options for preventing migraine. Would you walk us through the rationale behind that endorsement?

Dr. Ailani:
Sure. Our guidelines from the American Academy of Neurology and American Headache Society are running a little bit behind when looking at preventive treatments. So in order to help all of our membership and also help clinicians take care of people with migraine, the American Headache Society executive board, and the board at large, really decided to try to focus on recommendations for day-to-day treatment of migraine. Our original recommendations were to consider anti-CGRP treatments as maybe second- or third-line preventive options. But over the course of the last two to three years, the amount of evidence showing safety of anti-CGRP treatments, showing efficacy, and even showing efficacy head to head with drugs like erenumab—which is an anti-CGRP monoclonal antibody—compared to oral generic preventive medication, topiramate. And there was a head-to-head study that showed that patients tolerated erenumab better. So they, of course, stayed on the treatment and had a pretty drastic reduction in migraine over the three-month time period compared to topiramate, where a majority of patients were stopping treatment.

So with these kinds of datapoints, the American Headache Society felt very strongly that the anti-CGRP treatment should be one of the first-line options. It's not saying this is absolute, you should always go to these first, but it should be a consideration.

Dr. Turck:
And the guidelines also mentioned gepants, which are CGRP receptor antagonists, as acute treatment options for migraine. So you'd mentioned the clinical trial comparing erenumab and topiramate head-to-head. But how do you decide between these newer agents and more conventional rescue medications like triptans or NSAIDs?

Dr. Ailani:
So the American Headache Society Consensus Statement actually states that triptans are more effective than gepants when we're looking at meta-analysis. There actually hasn't been a head-to-head study comparing a triptan to a gepant since the new gepants have been around. So most of the time, I think a clinician will opt to try a triptan in a patient first. If this medication either isn't effective or the patient is having side effects to the treatment, which unfortunately, is not uncommon—triptans do tend to cause some patients to have fatigue or sedation, they might notice some nausea from the treatment, they might have chest pain or shortness of breath, just the sensation we call a triptan sensation that makes them a little bit uncomfortable when taking the treatment option—and so if they experience any of these things, that's usually when we'll try to move on to a gepant for acute treatment for migraine.

Now, I think it's important to realize the clinical scenario that we see very commonly in practice, which is a patient who finds a triptan to be very effective, but because of sedating side effects, tends to delay treating a migraine attack. And so they might say something like, 'Well, the medicine works, but my attacks are really long,' and when you try to dig into what happened the last time they had a migraine attack, they'll tell you, 'Well, I didn't take my medication right away because it makes me tired and I can't drive home,' or 'I can't pick up the kids,' or 'I can't really function at work.' And so if they're giving you that kind of information, it's really important to switch to another acute treatment option that doesn't come with those side effects for them. So that might be a time that I would switch a patient to a gepant.

Dr. Turck:
And when do you typically consider shifting a patient from an acute or rescue-only approach to a preventative treatment strategy? And how does migraine frequency or disability shape that decision?

Dr. Ailani:
So guidelines suggest that if a patient is having four to six migraine attacks per month that we start to have the conversation about

adding a preventive treatment, because every patient needs an acute treatment, so they should all have something on board to treat an attack. But once they get to that four to six days a month, we have a lot of data that suggests disability starts to increase. And again, they're starting to miss days of the month of their life. And when you add that up, it actually reduces their lifespan by a few years. A few years spent in bed disabled is pretty problematic for the average individual.

If the patient, however, has two to three migraine attacks per month, but with each attack, they have a significant amount of disability, they're missing work, or their acute treatments all give them side effects so it's hard to take them, you're going to start to bring up that dialogue of maybe being on a preventive treatment to reduce frequency of attacks.

So it really always goes back to the patient, how disabled they are from their attacks, and how frequently that disability is affecting their day-to-day life.

Dr. Turck:
And before we come to the end of our program, Dr. Ailani, what are some strategies you use to employ shared decision-making and monitor treatment over time?

Dr. Ailani:
That's a great question. I think that we all think or hope we're doing shared decision-making, and I'm always learning more and more from my patients when they tell me, 'I don't know about these suggestions you're having. I'm afraid about this.' So I think the number one key to shared decision-making is listening to the patient and really trying not to tell them what you think they should do, but having a dialogue about what's important to them, what key factors are causing them to miss out on their day-to-day life, and what are key factors that are important when taking treatment. Some patients have no problem doing injections on their own. Some patients have no problem coming in for injections, but some people prefer oral medication. So I think listening to the patient and having dialogues about what's important to them and what's not and what side effects would they be nervous about really helps to tailor the conversation about migraine specific treatments versus nonspecific treatments.

And then kind of going through that option with dialogue and reminding the patient that just because we make a choice today doesn't mean that we have to stay on this choice if it doesn't work for them, and there are lots of options out there, and just making sure they're aware about that. I feel that that helps the most with the shared decision-making process: always bringing it back to what the patient is missing out in their day-to-day life as a reason that they're on treatment—not only prevention, but acute treatment.

And then every visit kind of returning to how satisfied are they with the treatment they're on? Do they want to make adjustments? I often find that I might want more for the patient, but the patient kind of wants to stay steady because of other things going on in life, so you have to respect that, and that sometimes can be a little bit tough, but that's where those follow-ups are really important.

Dr. Turck:
Well, with those strategies in mind, I want to thank my guest, Dr. Jessica Ailani, for joining me to break down the American Headache Society's latest guideline updates on migraine care. Dr. Ailani, it was great speaking with you today.

Dr. Ailani:
It was my pleasure. Thank you so much.

Announcer:
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