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Redefining Migraine Care: Early Diagnosis and Prevention Strategies

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 discuss common diagnostic delays in migraine care and evidence-based management strategies is Dr. Stephanie Nahas. She's a Professor of Neurology at Thomas Jefferson University and the Associate Director of the Headache Medicine Fellowship Program at Jefferson Headache Center.

Dr. Nahas, thanks for being here today.

Dr. Nahas:
Thanks a lot for having me.

Dr. Turck:
Well, to kick things off, Dr. Nahas, would you describe the types of migraine presentations that tend to slip through the cracks in primary and neurological care settings?

Dr. Nahas:
Because migraine is more than just a headache, a lot of patients do wind up seeking consultation in other care settings and with other chief complaints besides headache. Migraine is typified by headache. In fact, the word migraine comes from ancient Greek, meaning half the head. And that typifies the pain of migraine attacks: pain on one side of the head. But there's also light and sound sensitivity and nausea and/or vomiting, which are part of the criteria for migraine. But other symptoms, such as neck pain, mood changes, and prodromal symptoms—which can include lightheadedness and minimal sensitivity to light or other things in the environment such as smells or particular visual stimuli—can all be part of migraine and might overshadow the pain.

In addition, facial pain can occur with migraine. Grinding of the teeth and sinus symptoms like congestion, rhinorrhea, or itchy, water eyes all may lead individuals to think that their problem is due to something else, like a sinus, neck, or eye issue. And so initial consultation may be to a chiropractor, dentist, or allergist. Most patients, though, with migraine, are seen in primary care and may volunteer that in addition to their headaches, they have these other symptoms leading to diagnostic pitfalls of ordering CT scans of the sinuses, for example, sending a patient to pain management for injections into their neck, or to chiropractic care for neck manipulation when really, the problem is migraine.

Dr. Turck:
Now, with that in mind, what role do clinical tools like the ID Migraine Screener play in facilitating early diagnosis, particularly when used alongside patient history evaluations?

Dr. Nahas:
I really like the ID Migraine Screener. It's simple and easy to remember. There are three questions to pin the diagnosis, and we say 'pin' the diagnosis with intent because those three letters, PIN, stand for these three key questions that you can ask an individual who's bothered by headaches to try to get at that diagnosis of migraine. P stands for photophobia. So, if you ask simply, does light bother you more than it should when you've got a headache? The I stands for incapacity. Are you impaired? Is your functional activity impaired when you're having an attack? And finally, the N stands for nausea. Are you sick to your stomach when you have an attack? If someone answers yes to two or three of these questions in the absence of red flags in the history, it's overwhelmingly assured—almost 100

percent, well over 90 percent of a positive predictive value—that that individual has migraine.

Dr. Turck:
Now, how important is tracking headache patterns overtime, especially when determining which patients are the best candidates for preventive therapy?

Dr. Nahas:
The whole concept of headache calendaring is actually quite complicated. Most folks would think it's pretty simple. Just get a calendar and write down when you're having headaches. Write down what you think might have triggered them. Write down what you took for them. But this can be a painstaking and laborious process, especially for individuals who have frequent attacks and are trying not to focus on their suffering. So, calendaring really is not for everybody. But I do suggest it for patients who are newly diagnosed with migraine so they can establish a baseline. It's quite common for patients to underestimate or overestimate what their burden of headache really is. Furthermore, many individuals focus only on the worst of the worst attacks, and we may be missing the opportunity to identify high-burden migraine if somebody is only reporting that they have four really severe attacks per month. We might think that that's all that they're dealing with if we don't ask about other milder headaches that that individual might not think are important. Let's say, for example, they live with mild-to-moderate headache almost every day and they have for years and they've learned to acclimate to it, and they're really only telling you about the most severe days—you might miss that they could actually have chronic migraine as opposed to episodic migraine.

It's also important to track when new treatments are being initiated so that we can be sure whether the treatment is actually making a meaningful difference. And this, again, is something that can be challenging for patients to identify on their own if they're not writing it down and they're trying to ignore the fact that they have this terrible disease. But when the disease is stable and static, no matter what the burden may be, it may not be necessary to track acute headache attacks. The one thing that is probably most important to track is how often acute medication is being taken. And when I want patients to be keeping a record of the pattern of their disease, that's the one that's most important in my mind. If they can only track one thing, I would ask them to do that. And there are a few reasons why. Number one, we want to know that acute treatment is working. When acute treatment is not optimized, that's a risk for the disease progressing. Number two, if acute treatment is being utilized too much, more than about two to three days per week generally speaking, or 10 to 15 days per month, that also is a risk for medication overuse and medication overuse headache, which can have a number of consequences, including disease destabilization as well as toxicity from the medications.

Dr. Turck:
For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Dr. Charles Turck and I'm speaking to Dr. Stephanie Nahas about how we can improve early intervention for patients with migraine.

So, Dr. Nahas, now that we've discussed diagnosis and patient assessment, let's switch gears and talk about preventive care. While it wasn't traditionally considered unless patients had frequent attacks, recent updates from the American Headache Society advocate for the use of preventive treatment to reduce migraine attack frequency, intensity, duration, and disability. So, would you give us an insight into the role of preventive strategies and why we should start thinking about them earlier?

Dr. Nahas:
This is perhaps one of the biggest pitfalls that I see in patients referred to me who have not been recommended to start preventive treatment early enough. Often it happens too late, when the disease is obviously destabilized and derailing that person's life. And preventive treatment really should start much earlier than most folks would think. We have a number of different benchmarks, if you will, or rules of thumb as to when to start to consider preventive therapy. But really, they all hinge around disease burden. When the disease is burdensome enough to warrant it, that's when preventive treatment ought to be offered. But what is burdensome enough?

Well, one way to look at it is by headache frequency. We know that at a headache frequency above about once per week, or 52 times per year—this is based on epidemiologic data following individuals over time—that connotes a sharp increase in the risk for progression from low-intensity episodic migraine to higher-frequency or even chronic migraine, which are far more burdensome to the individual as well as to society: much more costly, much higher healthcare resource utilization. And comorbidities to migraine can also play into that.

But besides just headache frequency, we want to know about the disability associated with the disease, and that's both within attacks as well as outside of attacks. During the attacks, they can be as severe as to be as disabling as quadriplegia. The World Health Organization has made that a statement. But even in between attacks, individuals may live with minor symptoms of migraine—these so-called interictal symptoms, where they can feel like they're on the verge of an attack. They feel some tension in their neck that might make them afraid to engage in certain activities that could trigger an attack. They might have light sensitivity which may limit their ability to participate in certain activities. And that interictal anxiety of fearing when the next attack may come, especially if acute treatment is

not reliable for that patient, can be a hard way to live.

Dr. Turck:
Also in the guideline, the American Headache Society recommends the use of calcitonin gene-related peptide, or CGRP-targeted therapies as first-line options for migraine prevention. In your experience, how have these therapies changed the preventive landscape and enhanced care for patients who suffer from migraines?

Dr. Nahas:
When these therapies first started coming out, we were filled with joy because we in the headache community have been waiting for them for so long. It had been decades since a targeted treatment designed to address what we know about the pathophysiology of migraine had come to the market. The last thing we had were the triptans, which started coming out in the 1990s. So fast forward to 2018 when the first CGRP-targeting preventive medication came out, and then soon to be followed by several others—now we're not even in a golden era but more of a platinum era of managing migraine with these therapies, which have been targeted towards the pathophysiology, but in a different pathway: the CGRP pathway.

What's also great about these treatments is that they generally are very well tolerated. They appear to be much safer than most of the currently available older options, which are not intended for migraine but just happen to work for them. And the dosing tends to be a lot simpler with no titration required and ease of use. So, these therapies have seen a vast uptake among clinicians and patients alike.

Now, that's not to say that they should be offered first for every patient. They should be considered among first-line options based on the broad spectrum of evidence for efficacy and tolerability. But they may not be suitable for all patients. So, I still will use some of these older oral preventive treatments. And it really comes down to a tailored assessment and shared decision-making between the clinician and the patient to decide which option is best for them. And what may factor into this decision is the potential for adverse events from the proposed treatment, the comorbidities that the patient also has, and of course, access to that treatment.

Dr. Turck:
Before we close, Dr. Nahas, how could shared decision-making improve outcomes in the context of preventive therapies for migraine?

Dr. Nahas:
This is something that I have felt is important throughout my time practicing headache medicine. Connecting with patients with headache is really key to enhance that clinician/patient relationship. By and large, individuals with migraine have lived a highly stigmatized existence. Many patients have had headaches since childhood and they've learned to kind of be quiet and shut up about it because other people don't get it. This is an invisible disease, which can unpredictably take a person away from their duties, activities, and the fun and joy in life. And it can be very humbling, and patients learn to sort of hide their disease. They don't even want to talk about it. So I laud any patient who comes to clinical attention really seeking health. It took a lot for them to get there. We know that perhaps half of individuals living with migraine in the United States are not even diagnosed, and many have not even seen a clinician about it, so that first step is very, very important.

In addition, you might only have one chance with that patient whose been so frustrated living with this disease all their lives, or most of their lives, and not getting the kind of treatment and respect that they deserve, and you want to pick a treatment that you think they're going to be able to adhere to and that has a high likelihood of being efficacious. So when I am sitting with a patient before me, I always give them at least two options for acute and preventive treatment. And oftentimes, I give them more than just those two options.

In addition, it's not restricted to medication. We recognize that nonpharmacologic treatment strategies, both in the acute and preventive arenas, are of tantamount importance, especially for patients who may want to avoid excessive medication for whatever reason. We must remember that when we're treating patients for disease, we're treating patients, not just the disease. And taking the whole picture into consideration is really critical. And that shared decision-making model really allows patients to buy in to their treatment decisions, and it really does improve adherence to that treatment.

Dr. Turck:
With those final thoughts in mind, I want to thank my guest, Dr. Stephanie Nahas, for joining me to discuss early diagnosis and preventive care for patients with migraine. Dr. Nahas, it was great speaking with you today.

Dr. Nahas:
Thank you for giving me the opportunity. I really appreciate it.

Announcer:
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