

MAKING A MIGRAINE TREATMENT PLAN

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DISCLOSURE INFORMATION

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- Lilly — Advisory Board/Speakers Bureau
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Medical Co-Director, Ctrl M Health

RESEARCH SUPPORT

- Amgen
- Autonomic Technology
- Colucid
- Cumberland
- Dr. Reddy Laboratories
- Eli Lilly
- Novartis
- PCORI
- Scion
- Teva
- Zosano

THIS IS ALL I AM GOING TO SAY ABOUT:

- **Diagnosis**
- **Calendars**
- **Triggers**

MIGRAINE OR MIGRAINE PLUS

- Rebound
 - Abortives on too many days
- Inflammation
 - E.g. rheumatoid arthritis, etc
- Other pain
 - The closer to the head (neck, tmj) the worse
- Anxiety/Depression
- Obesity
- Poor sleep
 - Insomnia
 - Snoring, sleep apnea

**FIX ALL
THE
“PLUS”
THAT YOU
CAN**

WHAT IS IN YOUR BOXES?

ABORTIVE	PREVENTIVE
MIND	BODY

CREATING A MIGRAINE HEALTHY LIFESTYLE

- **CORE HEALTH**
 - Hydration, nutrition, sleep
- **MOVEMENT**
 - Develop body awareness, a migraine safe movement routine
- **SELF AWARENESS**
 - Relaxation, meditation, emotion-regulation, mindfulness
- **CONNECTEDNESS**
 - Engage with people: work, play, and relationships
- **SELF EFFICACY**
 - Confidence in ability to achieve goals: self-regulation, support, mastery, observing success of others
- **GROWTH**
 - Seeing setbacks as learning opportunities: acceptance, commitment, behavior change and celebrating successes

Disclosure; I am medical co-director of Ctrl M Health

STIGMA TYPES

RECOGNIZE AND HAVE A PLAN

Interpersonal
micro aggressions

Structural
Laws and policies

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graph TD; A[Interpersonal micro aggressions] --> C[Self-stigma]; B[Structural Laws and policies] --> C;
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Self-stigma

Low self esteem
Depression/anxiety
MORE PAIN!
Concealment
Presenteeism
Low Participation Rates

ADVOCACY: THE GREATEST STIGMA BUSTER

- Tell your story (well)
- Language: use CHAMP language and image guide
- Be seen (come out)
 - Do it well
 - Seek advice
- Insist on accommodations
- Support others with your disease
- Participate in the movement
 - It is the only way things change

GENERAL PRINCIPLES OF ACUTE TREATMENT

Tailor treatment to both patient and attacks

- Recognize triggers and mitigate them
- Treat early
- Bypass the stomach (more often than you think)
- Use nonpharmacologic treatment (maybe solely)
 - Quiet, rest, cold compresses, relaxation, biofeedback, meditation
- Use (but don't overuse) acute medications
 - **Stratify care:** first line, backup, and rescue treatment
 - *Consider comorbidities when choosing*

ACUTE MIGRAINE MEDICATIONS

□ Non-specific

- NSAIDs
- Combination analgesics
- Neuroleptics/antiemetics
- Corticosteroids
- Opioids (not recommended)

□ Specific

- Ergotamine/DHE
- Triptans
- Gepants
- Ditans



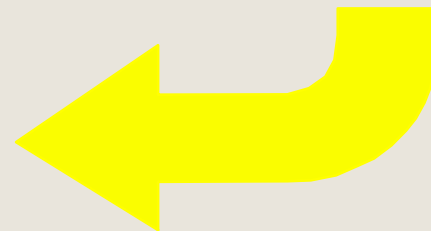
MAY NEED BACKUP OR RESCUE

Within Attack

Initial Therapy

Based on attack profile,
associated symptoms,
and level of disability

Back up and
Rescue Therapy



If Fails

THE FOUR COLUMNS: MIX AND MATCH

Triptans/Ergots	NSAIDs	Dopamine	Gepants
Sumatriptan	<i>Short acting</i>	Prochlorperazine	Ubrogепant
Rizatriptan	Ibuprofen	Metoclopramide	Rimegepant
Naratriptan	<i>Longer acting</i>	Promethazine	
Zolmitriptan	Naproxen	Chlorpromazine	
Almotriptan	<i>Others</i>	Haloperidol	
Eletriptan	Diclofenac	Olanzapine	
Frovatriptan	Indomethacin		
DHE/Ergotamine	Etc...		
Lasmitidan			

PROBLEMATIC (REBOUND HEADACHE)

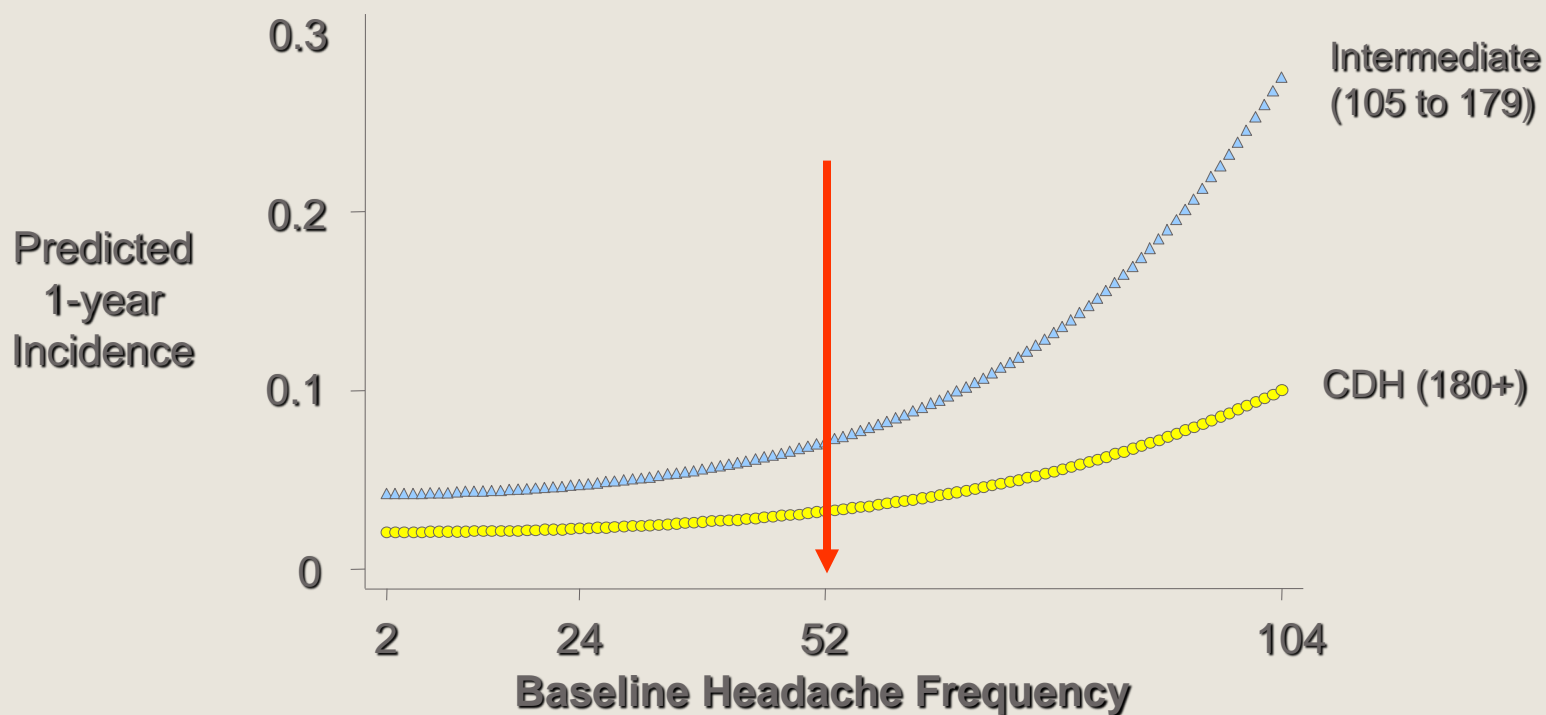
■ Opioids

- Percocet
- Morphine
- Vicodin
- Dilaudid
- Tramadol, Ultram

■ Butalbital

- Fioricet
- Esgic

ATTACK FREQUENCY AT BASELINE PREDICTS FUTURE DAILY HEADACHE



*Top line predicted incidence of intermediate frequent headaches (105 to 179 days/year) Bottom line shows predicted incidence of CDH (180+ days/year).

Scher AI et al. *Pain*. 2003;106:81-89.

Consider Prevention When

1. Migraine significantly interferes with patients' daily routine, despite acute treatment
2. Frequency attacks (>1/week) with risk of CDH or Rebound
3. Acute medications ineffective, contraindicated, troublesome AEs, or overused
4. Patient preference
5. Special circumstances such as ***Stroke-like attacks***

TRANSITIONAL (BRIDGE) STRATEGIES (OUTPATIENT)

□ NSAID

□ Antinauseant

▪ Antinauseant+NSAID

□ Steroid taper

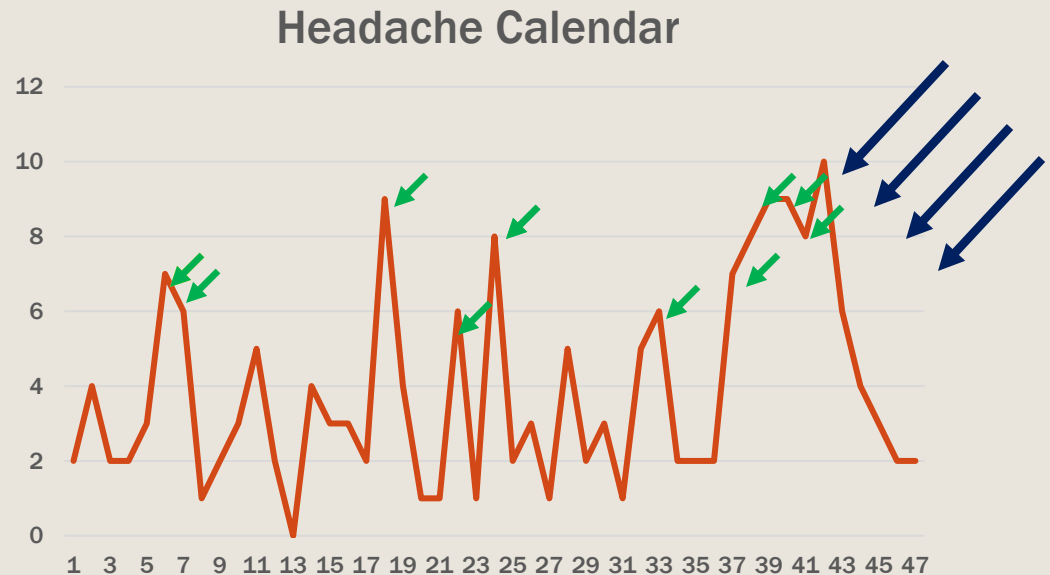
□ Tizanidine

□ Triptan

□ DHE nasal spray

□ Gepant?

□ All of the above may need a rescue treatment



INPATIENT VS. INFUSION

- More graded delivery of medication
- Serious drug withdrawal must be inpatient
- Psychiatric assessment
 - Mandatory psych consult
- Other consultations
- Opportunity for education
- Less disruptive to patient
- Less expensive
- Smaller knowledge infrastructure to maintain
 - Fewer nurses
 - Fewer administrators

PREVENTIVES

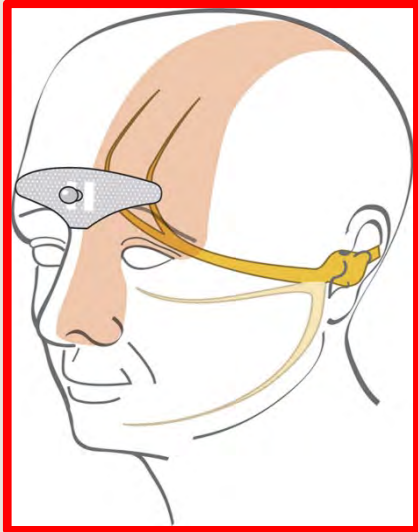
- Antidepressant
 - Amitriptyline, Nortriptyline
 - Venlafaxine, Duloxetine
- Blood pressure meds
 - Beta blockers – propranolol, atenolol, timolol, etc
 - ACE/ARBs – lisinopril, candesartan
- Seizure meds
 - Topiramate
 - Divalproex
- Botulinum toxin
- Monoclonal Antibody- Aimovig, Ajoovy, Emgality, Vyepti
- Miscellaneous – memantine, cyproheptidine,

“NATURAL” PREVENTIVES

- Petadolex (*Petasides*, or butterbur extract)
 - 150 mg/day
- B2 (riboflavin)
 - 400 mg/day
- Magnesium Oxide
 - 400 mg daily to TID
- Feverfew
- Coenzyme Q10
 - 150-300 mg/day and up
- Melatonin
 - 3-15 mg and up
- Medical Marijuana
 - CBD twice a day; THC as needed



WHAT'S YOUR DEVICE?



SUMMARY

- Ok, you have migraine
- How often, how bad, are there any triggers (there often are not)?
- How big a deal is migraine stigma in your life?
 - **Advocacy!!!**
- What else is going on that is known to worsen migraine? Can you make that better?
- What are you doing to create a healthy lifestyle for someone with migraine?
- Abortive treatments
 - Avoid rebound
 - Layered plan
 - May need bridge, infusion, or hospitalization
- Preventive treatments
- Devices