



Migraine

Prevention Summit

ISSUE No.2 The Importance of Communicating With Patients

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Findings From the *Migraine Prevention Summit*

The National Headache Foundation (NHF) convened an interdisciplinary panel in Chicago, Illinois, to discuss recent developments in the understanding of migraine and current treatment strategies. This newsletter is the second issue in a series of proceedings of the *Migraine Prevention Summit*. This issue contains important information about communicating with patients with migraine, determining level of disability, and discussing preventive treatment options. Other issues include a summary of the *Migraine Prevention Summit* outcome; an overview of the diagnosis and treatment of migraine; a case study with patient commentary; and a review of the advances in preventive therapies for migraine. Look for upcoming issues over the next several months or visit the NHF online for NHF *Migraine Prevention Summit* proceedings and other educational materials: www.headaches.org.

Recent Study Shows Need for Improved Communication With Patients

A recent study, the American Migraine Communications Study (AMCS) highlighted the need for improved communication between patients and healthcare professionals. Results showed healthcare professional-patient interactions regarding migraine are often dominated by closed-ended questions primarily about frequency of attacks. Only 10% of visits addressed migraine impairment in any way.

Further, patient interviews by researchers following the clinician's assessment revealed healthcare professionals' and patients' perceptions of frequency and severity of attacks did not agree in 55% and 34% of cases, respectively. The pattern resulted in a lack of discussion of preventive therapy in 50% of cases who met criteria for initiation of preventive therapy. Investigators concluded that use of open-ended questions may lead to more effective assessment of the total degree of migraine impairment experienced by migraineurs, possibly revealing more patients who may be suitable for migraine prevention.¹

Diagnosis, Evaluation, and Assessing Disability

Presentation of migraine may not strictly follow the IHS definition.² Migraine is characterized by its impact on patient quality of life and the pattern of attacks.³ In a patient with recurrent disabling headache, migraine is the most likely diagnosis. A migraine screening tool, ID-Migraine was developed to identify likely migraine sufferers based on the presence of 2 of 3 cardinal features: photophobia, inability to function, and nausea (recalled with the mnemonic PIN). Patients exhibiting 2 of these 3 symptoms during a headache attack have a high (93%) probability of migraine diagnosis.⁴

“If somebody is motivated enough to seek out medical help, it’s probably migraine.”³

— Richard G. Wenzel, PharmD

Following diagnosis, patients are assessed to determine level of disability and attack frequency, and then a treatment program is planned. Patient diaries are useful to help patients more accurately quantify frequency and severity of attacks, identify possible triggers (including food, environmental factors, stress, and other causes), and determine response to medications. In addition, it is important to assess the patient’s disability and the level of impairment not only during the attack, but also between attacks (the interictal burden of migraine). Investigators in AMCS recommended using open-ended questions to facilitate assessment of total impairment due to migraine (see inset).¹ Practitioners should also probe for the presence of other symptoms, including sleep disturbance, irritability, frustration, and feelings of guilt or depression.³

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“Prevention was never discussed until I went to a headache center.

The primary care physician gave me acute medications, and when one would stop working or I didn’t like the side effects, then I’d try another one.”³

— Debbie Sacchetti, patient

Migraine Prevention Summit

panelists discussed the use of open-ended questions to assess disability, as well as the impairment patients may experience between attacks. Patients may not be fully aware of their level of impairment or reluctant to discuss disability, and careful probing may be needed to illicit an accurate clinical picture. For instance, Roger K. Cady, MD, asks patients to list daily activities, including leisure activities, on routine patient forms. During clinical evaluation,

he then asks patients what they do on days that they have migraines, as well as days that they do not. If patients are not participating in routine and leisure activities, even on days when they do not experience an attack, that may indicate a substantial impact on patients’ lives—even on days when they are not experiencing an attack. Patients who avoid leisure activities due to migraine may be candidates for preventive therapy.³

Similarly, Kathleen Cahill, MS, CNS, ARNP, asks patients what they have given up because of migraine to determine total impairment. Christine M. Lantin, PA-C, considers how often a patient comes into the office with disability and workmen’s compensation paperwork in determining level of impairment. Frequent requests for disability compensation may reflect a high degree of impairment resulting in an inability to work.³

“Patients don’t realize how much migraine has impacted their lives until they start thinking about where they were and where they are now.”³

— Kathleen Cahill, MS, CNS, ARNP

Throughout treatment, patient education remains central to optimal patient care. Greater understanding of their disease and treatment options will increase adherence with treatment recommendations, including both lifestyle modifications and medical interventions. Specifically, patients may be more adherent to preventive therapy

regimens when they recognize that treatment may help to reduce the frequency of attacks. Preventive therapy may take up to 2 to 3 months of continuous treatment to reach full clinical effectiveness. Thus, it is important to set appropriate patient expectations for therapy and clinical outcome and encourage patients to give preventive medications adequate time to work.^{5,6} Patients should not expect immediate efficacy or total resolution of their migraine attacks, as data suggests that approximately 50% of patients experience a 50% decrease in migraine frequency on preventive treatment.⁷ Treatment should be initiated at the lowest effective dose, with the dosage increased slowly to achieve maximal clinical effectiveness with tolerable side effects.⁸ Finally, patients must be informed of potential side effects of treatment before initiating therapy.

It is important to set appropriate patient expectations for therapy and encourage patients to give preventive medications adequate time to work.

Preventive Treatment Options

The goals of preventive therapies in migraine treatment are to decrease the frequency, severity, and duration of headache attacks and to help acute medications work better.^{3,8} Preventive therapies may work through one or more of the following potential mechanisms of action: 1) raising the threshold of migraine activation by

Open-Ended Questions to Assess Migraine Impairment^{1,3}

1. How do migraines make you feel – even when you aren’t having one?
2. How does migraine impact your daily life?
3. How do migraines impact your work, family, and social life?
4. What activities have you given up because of your migraines?

(Probe to see if the patient avoids participating in hobbies and/or leisure activities out of fear of a migraine attack)

stabilizing a more reactive nervous system; 2) enhancing antinociception; 3) inhibiting cortical spreading depression; 4) inhibiting peripheral and/or central sensitization; 5) blocking neurogenic inflammation; and 6) modulating sympathetic, parasympathetic, or 5-HT tone.⁹

46% of migraine patients are unaware of preventive medication as a treatment option.³

Treatment decisions are based on several factors, including side effect profile, patient preference and contraindications.³ In addition, specific medications may not be appropriate for certain patients. Divalproex sodium is teratogenic in the first trimester and not recommended for women of child-bearing potential.¹⁰ Likewise, there may be a tendency to choose a treatment for migraine that also treats the patient's comorbid condition. This strategy is not ideal, however, as doses for migraine may be different from those for other conditions. Instead, healthcare professionals should design individual treatment plans to treat each medical condition with the optimal agent.³

“While it is tempting to strive for the therapeutic two-fer—managing two conditions with a single medication—it is not desirable to suboptimally manage two diseases. In the face of co-morbidity, it is preferable to optimally manage all disorders that are present.”³

— Richard Lipton, MD

Roles of Healthcare Professionals in Patient Education and Management

The panel emphasized the importance of healthcare professionals and patients working as a team, with each specialty contributing key elements, to provide

optimal care and educate patients with migraine. Primary care practitioners — including physicians, nurse practitioners, and physician assistants — serve as the gatekeepers to care, evaluating patients, diagnosing migraine, and initiating acute and/or preventive therapy. Thus, they must recognize the signs and symptoms of migraine, be familiar with screening tools, and be able to

“When I found out there were actually treatments to help prevent migraine, to change the cycle of migraine, I didn’t even know that they existed. So, that was news to me.”³ — Debbie Sacchetti, patient

FDA - Approved Preventive Therapies for Migraine

Class
Antiepileptic drugs
Beta-blockers

recommend appropriate acute and preventive medications. Patients may be referred to a neurologist or headache specialist if response to first-line treatment is inadequate, if a secondary cause of headache is suspected, or if their disease is complicated or they have multiple co-morbid conditions.³ In addition, healthcare professionals working in the primary care setting should prevent and recognize overuse of acute medications. To that end, developing a practice standard (such as, a maximum of using acute medication only 2 days per week) and clearly communicating to patients to stay within that standard is essential. Patients who begin to use acute medications more frequently should be reevaluated for effectiveness of migraine interventions and may be considered for preventive medication or referral to a specialist. Pharmacists also have an opportunity to identify medication overuse among patients who use over-the-counter medications, as well as those who overuse prescription acute medications, including the triptans.³

Conclusion

Recent results from AMCS demonstrate the need for improved communication between patients and healthcare professionals. Approximately 50% of patients who meet criteria for initiation of preventive therapy do not discuss this treatment option with their healthcare professionals. Increased use of open-ended questions may improve assessment of patient impairment due to migraine and facilitate discussion of migraine prevention therapy. All healthcare professionals involved in the care of patients with migraine play important roles in maintaining communication with patients throughout evaluation, diagnosis, and treatment. Special attention is needed to assess the level of disability due to migraine, as well as the interictal burden of migraine, to determine the need for preventive therapy.¹



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The Importance of Communicating with Patients
Second in a 4-part series

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NHF MIGRAINE PREVENTION SUMMIT CONSENSUS STATEMENT

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The interdisciplinary panel developed the following consensus statement highlighting the key findings of the *Migraine Prevention Summit*.

- Migraine is a chronic disorder, rather than an episodic disorder. Healthcare professionals treating patients with migraine must be educated about recent advances in the understanding of migraine and current treatment options.³
- Proper use of acute medications is essential to maximize their efficacy. Acute medications should be taken at the first sign of migraine (or during the aura, if present).³
- Acute medication is not always adequate to control migraine attacks. Preventive therapy should be considered in patients requiring acute medication more than 2 days per week and in those experiencing frequent disability during and between migraine attacks.^{3,11}
- Healthcare professionals need to determine patient disability and the total level of impairment migraine has on a patient's life, both during and between attacks, to better assess when patients may be appropriate candidates for preventive therapy. In addition, it is important to recognize how migraine affects other aspects of the patient's life, such as family and work life.³
- Preventive therapies include both medications and behavioral modifications.³ Patients need realistic expectations about treatment outcome, specifically time to response. Preventive therapies may take 6 weeks or longer to reach clinical effect. In addition, patients should be counseled on what side effects to expect and should be titrated slowly to the target dose.⁵
- Patients are important partners in the management of migraine. Open communication about treatment options and healthcare professional-patient support is essential to ensure treatment plans are followed. Adherence to treatment regimens, including both lifestyle changes and medications, is necessary to achieve optimal effect.³
- Migraine is a manageable disease. With communication and cooperation between patients and healthcare professionals, most patients can achieve greater control of their disease and reduce their disability.³

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