Episode 201: Headache and Migraine News, October 2024

Lindsay Weitzel, PhD:
Hello and welcome to HeadWise, the videocast and podcast of the National Headache Foundation. I'm Dr. Lindsay Weitzel. I'm the founder of Migraine Nation, and I have a history of chronic and daily migraine that began at the age of four. I'm excited to tell you that I am here today with a guest that we've only had on maybe once, and it was quite a while ago.

This is Dr. Susan Hutchinson. Hello, Dr. Hutchinson, how are you?

Susan Hutchinson, MD:
Hello.

Lindsay Weitzel, PhD:
I have asked Dr. Hutchinson to come on for our regular HeadWise news episode. She is a headache specialist and the founder of the Orange County Migraine and Headache Center in Irvine, California. She's sought after for her knowledge related to women and headache medicine. And I'm very excited that she's our guest today. We're going to go ahead and delve into our studies, because we have quite a few new and interesting studies that have recently been published.

We're going to start with a study that might be interesting for the parents in our audience. A group evaluated whether there was agreement between pediatric headache patients and their families on which treatments they preferred for their migraine disease. What did this group find and why was it important?

Susan Hutchinson, MD:
Lindsay, I think it's really, really important because I think sometimes as clinicians, we just end up talking to the parents when we're seeing children. And I think this study shows that it's not always going to be the same when you ask about what are their acute treatment goals, what are their preventive treatment goals. And there was some alignment.

This was a study that was done in Canada. And it took pairs of the adults with the child. And the children were between the ages of 9 and 18. And it asked them things about what was important to them. And it looked at both acute and preventive. Now, some things did align as you would expect. Both parents and the children wanted freedom from pain. They wanted relief from those associated symptoms.

And what was probably not too surprising, although we look at clinical trials looking at pain freedom at two hours, these children and their parents, they wanted to be better in one hour or less. In fact, some in 30 minutes. And I think that's important because I think we look at clinical trials, but I think in the real world, we want people to sometimes do better than the goals in the clinical trial. Now there was some alignment and it looked like both groups wanted an oral tablet that you swallowed for acute treatment. So they weren't as interested in things like injections. And you can imagine that, or even the nasal deliveries.

What was somewhat surprising to me is they both aligned on being interested in these noninvasive neuromodulators as perhaps a second line of treatment. And some of them are actually FDA cleared now for adolescents. So to me, that was exciting to know that there was that openness. But again, the bottom line is there was some differences in terms of what the goals and expectations were. And the adolescents were interviewed separately than the parents.

So what does this mean for us? I think if you're a parent listening, make sure that your child, your adolescent, is heard. What are their goals. Is there a difference that perhaps the provider, someone like me, needs to take into account. And not just have this discussion with the parent going on, but really engage the adolescent, the child. That's just so important.

Lindsay Weitzel, PhD:
I'm glad you said that. I happen to be the mother of a very young child with chronic migraine, and this just happened to me recently. I noticed that we weren't asking him in the room which one do you think works best out of all these zillions of medicines that you're on. And when we did, it was slightly different than what I thought worked best. So I think this is a great study and I'm glad it brought attention to these facts.

So another study out this month looked at the effect of migraine aura on daily functioning for us. There's previous data showing that the presence of aura is related to more severe migraine symptoms, and even to increased risk of psychiatric comorbidities. But the focus of this particular study was to see if aura affected our ability to function when migraine strikes. So can you please tell us what they found?

Susan Hutchinson, MD:
It was actually very insightful for me. And I will tell you, in my own experience, my patients often have migraine with aura, but they also get migraine attacks without aura. And many of them really dread the ones with aura because their thinking is they're not going to function as well. And what was very interesting about this, and I always look at how many people are in this study also, this was not 30 adults. They took 554 adults with migraines. So to me that's fairly robust. And they followed them over 90 days. And so you're looking at a lot of migraine days.

And what they found is that aura, which hopefully your listeners know, it's those reversible neurologic signs and symptoms that can occur before a migraine. Usually it's visual, but it can be something like numbness on one side of the body, tingling, slurred speech. And to be honest, sometimes it's kind of scary when patients get those neurological signs and symptoms.

But what was interesting, in addition to the aura, when they had aura, there was higher disability ratings on those days compared to when they don't have aura. And it wasn't the pain itself. So it wasn't that the headache itself was bad. What it was, was things like the nausea, the sensitivity to light, the sensitivity to noise. And also this thing called allodynia, which most of your listeners probably know, but where you get this incredible sensitivity to touch that normally you don't have. For example, my patients might say, why does it hurt Dr. Hutchinson when I even press lightly or I can't put my hair in a ponytail.

So the point is that when patients had aura, it was correlated with having more of these non-pain symptoms. Which having migraines myself, sometimes the nausea is worse than the head pain. So you've got the nausea, the sensitivity to light, the noise, the allodynias. So, I think this shows that yes aura can be predictive of having greater disability. Not from the head pain itself but from these other non-head pain associated symptoms of migraine.

Lindsay Weitzel, PhD:
So let's move on to our next study. And it's one that you are actually an author on. It is using the large OVERCOME database that includes over 61,000 people. As we all know, there are so many people out there with migraine who do not actively seek medical attention for numerous reasons. Some might have had a bad experience or given up. Others feel nothing's going to help or maybe their current level of pain and disability isn't bad enough to seek treatment.

But this study sought to discover which factors were associated with actually seeking medical care for migraine. I actually found this information pretty interesting. What did your research group uncover?

Susan Hutchinson, MD:
I also found this very interesting, Lindsay. And it's been a pleasure to be part of this OVERCOME study group because this is pretty recent data. When you mention the numbers, incredible. This was over 61,000 persons in the United States with migraine that were studied. And so, I think it's very reflective of current migraine because this was from the years 2018 to 2020. And that's a lot of patients with migraine, over 61,000.

And about half of them, 51% of that large number, had sought care for their migraine within the past 12 months. The other half did not. So you wonder, why are some people going and seeking care for their migraine and what about the 50% that weren't.

So here is what was found in this. Some of this probably makes sense. That those that did seek medical care within the past 12 months, they had higher interictal burden, and I'll explain what that is in a moment, higher disability, and how they determine that was there's a questionnaire called the MIDAS to see how much the headaches have been affecting you, and allodynia. There's that term allodynia again.

Well, severe interictal burden, that's when you're in between the migraines. And so you don't have a migraine, but often you're wondering when is the shoe going to drop, when are you going to get your next migraine. And often patients that have this interictal burden, they may have depression and anxiety. So the point is, even when they don't have a headache, they're not really enjoying their life. That's the way I look at it.

So if patients had that severe burden, even in between attacks or they had that allodynia, that incredible sensitivity to light touch, or they just had major disability based on looking at things like missed days of work, missed days of school, productivity being reduced by over 50%. Those were the factors that were identified as what really got people more likely to go on and seek medical care, and that makes sense. But I think it's sad that not 100% were getting care for their migraine within the past 12 months, because there is so much we can do now when patients come to us.

Lindsay Weitzel, PhD:
I'm glad we defined interictal burden, because I think there's a lot of us that, some of us actually just have pain all the time, too. And that's quite a burden.

Next we have a study where members of the American Headache Society, who provide care to patients with migraine, were surveyed and asked how they treat patients with status migrainosus in the outpatient setting. Now, technically, status migrainosus is defined as a debilitating migraine attack lasting more than 72 hours. But there is no standard treatment for this, at this time. So what were the most frequent responses from these providers on how they treated status migrainosus?

Susan Hutchinson, MD:
This was very insightful for me and I was actually one of the ones that responded to this survey. It was sent out to all members of American Headache Society. And there's almost 1900 of us, and 196 responded. And I was one of them. And over half of us are certified in headache medicine through UCNS. But what was interesting to me, and I was happy about this, is most respondents said they don't wait till the headache has gone on for over 72 hours. They want to intervene before that, which I really think is good because we don't want people to suffer. But when we think about the definition of migraine, we think about a headache that can last 4 to 72 hours if it's not successfully treated. And so beyond the 72 hours is when you think of this as status migrainosus. But I was very pleased that myself and most of our colleagues, they treat before the 72 hours.

What was interesting to me is the majority, 76%, they use outpatient medication at home, hopefully something you've already designed as part of your treatment approach. What was interesting to me is I tend to have patients come in and offer them a Toradol shot or an occipital nerve block. But I have to remember that my patients, it's pretty convenient where I'm in Southern California so think about patients in a rural area, how wonderful that their provider has a treatment plan in place.

But I was quite surprised that 76% use outpatient medication. About 11.2%, which would be me, preferred a person come in to give them a procedure. Only about 6.1% would refer to an infusion center, another 6.1% to the local emergency room, and a very, very small number, 0.5%, would do direct hospital admission.

Now, what's interesting is of the five preferred medications, the number one was corticosteroids. You think about, sometimes we use the term steroids, prednisone. And it was interesting to me because I had forgot, sometimes just a very short course of a steroid, which is a very potent anti-inflammatory, can really, really help. And the other thing that was used, quite frankly, were the non-steroidal anti-inflammatories. And there are some that are prescription strength that may work better than over-the-counter. And the third is this category called neuroleptics, which sometimes I think of as dopamine antagonists. But there are some of the anti-nausea medications, things like you might have heard of, Compazine, Phenergan, Reglan. They can actually be quite good in rescuing.

And so I thought this was very interesting. And even for me, it caused me to think, wait a minute, maybe I'm too quick to have patients come in for Toradol and a nerve block. Maybe they would prefer to have a pack of steroids at home, to have maybe a Phenergan suppository. But I was so happy Lindsay, that the majority of us providers don't make a patient suffer for 72 plus hours. We like to intervene sooner.

Lindsay Weitzel, PhD:
It's nice to know there's so many options. I think that a lot of our listeners have probably tried a lot of the things you just mentioned. Some people probably even have Toradol at home. But I think it's nice to know there really are a lot of options. And some people do have standing orders at infusion centers too, in case they get stuck with over 72 hours of a really severe migraine. It really does vary, I think, based on the patient and the provider, etc. But I love hearing the data when they do a survey like that.

Susan Hutchinson, MD:
And thanks for bringing up the point, because I have done that for patients that get into trouble. Let's say a woman who gets severe menstrual migraine, and it could just take off and she's dehydrated and vomiting. How wonderful to go to an infusion center instead of the emergency room. Because in the infusion center, it's often excellent skilled nurses that are great at starting an IV, but you can get the IV fluids. You can get things like IV magnesium, IV Toradol. And it's so much more comfortable than the emergency room. So thank you for reminding me of that.

Lindsay Weitzel, PhD:
We're going to move on to a study that's close to my heart because it talks about neck pain with your migraine, which seems like me and most of my family members seem to have. So for those of us who get neck pain during our migraine attacks, our next study looked to see what was different about people whose migraine attacks come with neck pain versus people who do not experience this symptom.

This data was from the CaMEO study, which we often hear of and we've discussed on this podcast before. So, Dr. Hutchinson, how prevalent was neck pain among people in this study and what else did they find out about this group of people?

Susan Hutchinson, MD:
Great question. In fact, this was the CaMEO International Study. So it didn't look just the United States. There were six different countries involved. And what was interesting is nearly 70% of patients with migraine, and this was again a very large number of respondents, over 51,000. That's a lot. So nearly 70% of those with migraine had associated neck pain with their headache. And it was a much lower number if they did not have migraine. And not only that, but neck pain was associated with greater disability. And it sounds like you might relate to that. And also more depression, anxiety, and more of that cutaneous allodynia, again, that sensitivity to touch.

And when I reflect on this, I think it kind of makes sense, because if you have neck pain, that probably means some of those cervical node nerve roots and you're getting a lot more involvement as that migraine takes off. And when you think of cutaneous allodynia, when I think of that, I think, wait a minute, it's no longer just a peripheral problem. That headache has taken off and it's going to the brainstem and the higher brain centers. So it kind of makes sense that the neck pain, the cutaneous allodynia, to me it's almost like that headache is just taking off.

And so what does it mean? I think we may need to be more aggressive. And when patients have neck pain with their headache, maybe think of that person as needing a more aggressive treatment approach.

Lindsay Weitzel, PhD:
It's funny as you were saying that, I didn't think of this when we were talking about this data. But gosh, even as a little kid being daily from toddlerhood, I happen to have one of those moms that just really always wanted to do my hair. And I was like, no, no, no, just don't touch my hair. I always had the neck pain with the migraine. So the allodynia was a thing.

Susan Hutchinson, MD:
Well that's a real thing because most girls love having their hair done. So the fact that you didn't want to have it done, you truly were having neck pain.

Lindsay Weitzel, PhD:
I was, neck pain, allodynia, the whole thing.

So, we'll move on to another one. Whenever data is published on any of these less common types of headache other than migraine, like cluster headache, I like to make sure we talk about it, even if it's a small study or hard to explain just because there's a lot less research on the other types of headache that aren't migraine.

So here we have a cluster headache study. This study was just published, and it looked at the location of pain in cluster headache, which is traditionally thought to be behind the eye. These authors found a couple of really interesting things. What did they find?

Susan Hutchinson, MD:
Here's what they found Lindsay. You are right. When we think of cluster headache, we think of that severe, boring, piercing pain in and around the eye, just on one side. We think of drooping of the eyelid and tearing. And yet everything that happens in a cluster cannot just be explained by that. What the study found is it's not just this peripheral local event. It looks like there's a lot going on with the occipital nerve, the occipital nerve root, probably higher brain centers. Why that's important is it means you don't just treat it locally. And this also can explain why, for example, in my practice I sometimes would do an occipital nerve block on the affected side. And we would do maybe topical anesthetic like bupivacaine. Unlike migraine, usually with cluster we add a little bit of steroid.

But the point is that even though the pain's here, Lindsay, we would do an injection back here, and it helped. So the bottom line is we think there's more going on in cluster than just the location of where the patient has the pain. And that's so important because that potentially is going to lead to better and more appropriate treatment options for this group of patients. It's called the suicide headache. I have migraine and I know how bad those are, but cluster is truly severe. So the more we can learn about it, this is really exciting and very important information.

Lindsay Weitzel, PhD:
Thank you so much for covering these studies with us and for being here. I hope that everyone learned a little something. And I hope that everyone comes back for our next episode of HeadWise. Thank you again.