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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Patient-Centric Approaches to Managing Migraines in the Female Patient

Announcer:
Welcome to CME on ReachMD. This activity, titled “Migraine and Women’s Health: Migraine and the Whole Female Patient” is provided by Omnia Education.

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Dr. Ailani:
This is CME on ReachMD, and I'm Dr. Jessica Ailani. Today, Dr. Dawn Buse and I will be discussing the impact of migraine on a woman's quality of life. We'll also examine how modulation of the calcitonin gene-related peptide, or CGRP, pathway has become an important focus in treating acute and chronic migraine. As an added bonus, a patient with chronic migraine will join us to share her experience.

Welcome, Dr. Buse.

Dr. Buse:
Thank you, Dr. Ailani. I'm happy to be here, and hello to our viewers.

Dr. Ailani:
So, Dr. Buse, can you briefly discuss the quality-of-life impact of migraine on women? And typically, how long do women live with migraine before they receive a correct diagnosis?

Dr. Buse:
Migraine can have a significant impact on quality of life and disability or ability for women that can include all sorts of aspects of life from the smallest daily details like deciding what to have for lunch, like taking care of household chores to the biggest life decisions, like choosing whether to have children, getting married, and everything in between. We know from large epidemiologic studies, as well as in the clinic, that migraine can impact negatively work, school, academic achievement, household finances, as well as the nicer aspects of life, social and leisure, family activities, hobbies, sense of self, and can be associated with significant stigma.

Now, in fact, about half of women with migraine in the US, and even more around the world, are never diagnosed. But among those who are diagnosed, it can take a long time to get to that journey. People will often live many years with migraine without realizing what it is. They may self-treat with over-the-counter treatments, and it may be a decade or longer before they actually get to see a physician and get a diagnosis.

Dr. Ailani:
Yeah, so I think these are all completely relevant things that we see in clinical practice.

Dr. Buse:
We're fortunate to have Alicia with us today. Alicia has had migraines since the age of 10.

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Alicia, welcome. Thank you so much for being with us and for sharing your story with us and our viewers.

Alicia:
Thank you. I'm happy to be here and tell my story.

Dr. Buse:
Thank you. Well, tell us. How has migraine impacted your life?

Alicia:
I started when I was 10 years old, and it was devastating and horrifying. I would beg my parents to take me to the doctor to put me to sleep. I don't know what it was they gave me, but it was a shot and it would put me to sleep. And it would bring me to the next day where I would have that migraine hangover.

They lasted from 10 to my late teens. I had a reprieve when I was in my 20s, and then when I got pregnant with my daughter in my late 20s, they came back with a vengeance. And I had recently relocated to New England; I got a promotion to a vice president. All of my bosses were all older men. Now I had these migraines. My immediate employees, which were mostly women, they knew about it, but I hid it from my salespeople, from my bosses, from everybody else. I had the baby and they went away. So that was great.

And then they came back with a vengeance during perimenopause. But they were different at this stage in my life. They were a chronic headache. Every single day I was in some type of pain. And I went to a slew of different doctors, and they all said, you know, “They’re tension headaches,” or, “It's just a headache.” And they sent me to neurologists, and I went to doctor after doctor after doctor. And then finally, I was re-diagnosed with migraine, which was a blessing because that led me towards appropriate treatment, but it was a long process to get to that point.

Dr. Buse:
Well, certainly, your story is very, very much representative of a lot of women with migraine, a long journey, a journey that changed, especially related to different hormonal and developmental milestones, which does happen for women with migraine.

You mentioned your treatment journey. What has that been like, and have you found a treatment regimen that works?

Alicia:
I’ve tried numerous medications. What really made a difference for me were the newer medications that came out, the CGRP medications. And for me, it seems like – I think I was a super responder. The first one I took, I felt like it cured me. And it worked for about a year and then not as well. And then I’ve kind of cycled through them. And I just recently had an infusion, which, it's been remarkable for me. But for me, it's not just one medication; I often will try neuromodulation in combination with a medication. And occasionally I will use over-the-counter medication. Naproxen seems to help me.

Dr. Buse:
Well, thank you. And that multimodal approach is an approach that can be very helpful for people who manage migraines. And that does follow along with the American Headache Society consensus guidelines and recommendations, of which Dr. Ailani is the first author on that, and those were issued in 2021 combining recommended medications.

So this was really helpful, Alicia. Thank you so much. If you were to give some advice to other women living with migraine, what would your advice be?

Alicia:
I feel, first of all, we need to be educated. People need to be educated, and there are enough resources out there available to people – laypeople, not people with medical backgrounds, but everyday patients. There's great information out there. But I think if you go to your doctor armed with, “Can we try this? Can we try this? Why haven't we tried this?” And so I think education is key.

Finding a doctor that you really feel like is in your corner is important. And it doesn't even have to be a doctor, an MD, it could be an advanced practice provider.

And then don't give up.

Dr. Buse:
Thank you. That is great advice. I think your story really highlights the challenges and the long journey of life with migraine and getting to an effective management strategy.

Alicia:
Well, hopefully it helps. Thank you.

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Dr. Buse:
It will. Thank you.

Dr. Ailani:
For those of you just tuning in, you're listening to CME on ReachMD. I'm Dr. Jessica Ailani, and here with me today is Dr. Dawn Buse and a patient with migraine. Our focus today is the impact of migraine on a woman's quality of life and how modulation of the CGRP pathway has become an important focus in treating episodic and chronic migraine in both preventive and acute treatment paradigms.

Dr. Buse:
Okay, Dr. Ailani, let's take a closer look at the science. Alicia actually mentioned CGRP, targeted monoclonal antibodies, gepants, she mentioned some of the newer treatments. What is the pathophysiologic connection between the calcitonin gene-related peptide, or CGRP, and migraine?

Dr. Ailani:
The studies have shown us in science that when CGRP levels are elevated in somebody who has a history of migraine, these people can actually have a migraine-like attack. And when they treat their migraine with a medication like a triptan, CGRP levels can actually come down. So this, you know, early discovery when we started to realize that there might be this relationship between CGRP and migraine, started to lead down the path of what if we suppress this protein, CGRP? Could we potentially block migraine from happening? So it led to the development of a whole category of medications, the gepants, which are CGRP receptor antagonists that block the ability of CGRP to bind to its receptor. And then also led to the development of CGRP monoclonal antibodies, which are treatments that either block CGRP from binding to its receptor or block the CGRP ligand. All of these treatments, their main goal is to stop CGRP activity and to potentially reduce the frequency of migraine or to treat a migraine attack when it's happening, depending on the treatment itself.

Why is CGRP potentially important in women? We believe that women have more potential for migraine, as Alicia was talking about, where she had migraine when she was pre-teenage years and then they got better in her 20s, came back in her pregnancy, and then got better again, and then came back in her perimenopausal time period. So you'll notice that these 3 times in her life all have a very strong hormonal link. There's been a lot of evidence within the relationship of estrogen fluctuations and migraine itself. And there's a belief that, when estrogen levels fall, this might make women more prone to having migraine attacks. And when estrogen levels peak during the cycle, that's actually a potential for when you might get an aura. And so this can happen during ovulation.

There are other different chemicals and hormones that can change as well that might play a role in hormonal fluctuations in migraine. These include chemicals like oxytocin and hormones like prostaglandin, which might also play a strong role in migraine but might also play a role in menstrual migraine.

Let's watch this brief video that teaches us a little bit more about the relationship of estrogen fluctuations, CGRP, and hormonal migraine.

[VIDEO PLAYS]

Dr. Ailani:
I hope you enjoyed that video.

Dr. Buse:
Dr. Ailani, that was a terrific overview and very interesting and informative. So we have all these options now available. Let’s put on your white coat. You’re in the clinic, how do you decide when it comes to treating one of your patients? What are the options you look at, and how do you make those decisions?

Dr. Ailani:
So it’s a great question. Usually in clinical practice, I do present all the options to the patients and then we really go through it and look at the profile and try to help the patient make the decision.

So these options, the first thing let's talk about is migraine prevention. We look at the patient and we decide are you episodic or chronic migraine? Thankfully, when it comes to the CGRP monoclonal antibody class, which includes eptinezumab, fremanezumab, galcanezumab, and erenumab, these are all approved whether you have episodic or chronic migraines, so regardless of the frequency. So when it comes to prevention with CGRP monoclonal antibodies, the things we're thinking about, does this person prefer an injectable medication that isn't dosed every day that they're either going to do at home or they prefer to come in for an infusion every quarter in the clinic? If they prefer to do it at home, then we're looking at side effect profile. Is constipation already a problem? If not, and they find a single injector once a month preferable, and maybe they liked the way the erenumab injector looks, we go with erenumab, or if that's

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preferred for insurance. If they prefer an infusion in the office, then we go with eptinezumab.

So you can see how we're really talking through the profile of the drug and the preference of how the drug is given to the patient.

Then I have my patients who, “Injections, are you kidding me? I don't like an injection.” So we're going to start talking about using a pill, like the gepant class, in which case we have 2 options: atogepant or rimegepant. In that case, we might be looking at side effect profile. Is this somebody who has a lot of constipation? Is this a patient who has lower frequency migraine? Or who has some months that are higher frequency, some months that are not that frequent, and really likes the flexibility of taking a medicine that can be used as an acute treatment and then some months increased to be used as a preventive treatment? That's a patient who might really like rimegepant as an option for prevention, as opposed to a patient who has stable migraine frequency at like 8 to 10 days a month and really needs a stable preventive treatment. So again, atogepant for that patient might be a great option.

Then when we're looking at acute treatment and we're looking at gepants, we have ubrogepant, rimegepant, and zavegepant. In these cases, we're looking at does the patient need a nasal spray option for fast onset and also has a lot of nausea? Zavegepant might be a good option there. Does the patient need a rescue with the same treatment? Ubrogepant would be a great option there. And again, does the patient like the idea of flexing between some months only using acute, some months using the same drug for preventive? Does the patient like an oral dissolvable tablet? Does the patient have long migraine attacks where a single tablet that can last the whole day is a really good option for their migraine attack? That's where rimegepant can be a good option.

So kind of talk through all this and see what the patient is comfortable with and what's really approved by their insurance plan. And that's kind of how we get to what's the right option for the patient in front of you.

Dr. Buse:
Well, thank you. That is a really helpful answer and something that everyone can take back to the clinic next time they're there seeing their patients.

Dr. Ailani:
Well, Dawn, that's all the time we have today. So I want to thank our audience for listening in and watching, and thank both yourself, Dr. Dawn Buse, and our patient, Alicia, for joining me and sharing all your valuable insights. It was really wonderful speaking with you today.

Alicia:
Great. Well, thank you for having me.

Dr. Buse:
Thank you, Alicia, for joining us, Dr. Ailani, for leading the conversation, and thank you to our listeners.

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