NHF Insights™ Healthcare Provider Series
Episode 4: Managing Migraine and Headache Disorder Diagnosis: A Guide for Clinicians

Hope O'Brien, MD:
Welcome to NHF Insights, the National Headache Foundation's podcast created with the support of our industry partners. We bring you fireside chats with experts on what's new in migraine and headache care. I'm your host, Dr. Hope O'Brien. I'm a board-certified neurologist and headache specialist and board president of the National Headache Foundation.

This episode focuses on managing headache diagnosis and is part of our Healthcare Provider Series. Today, we'll explore how to evaluate whether treatment is working, when to adjust care plans, when to refer to a headache specialist, and finally, the importance of accurate documentation in migraine diagnosis. Let me introduce you to today's guest Dr. Jaclyn Duvall. She's a board-certified neurologist and is UCNS certified in headache medicine, she is the founder of the Headache Specialists of Oklahoma. She's a national and international speaker, educator, and author of *The Basics of Migraine*. Welcome, Dr. Duvall.

Jaclyn Duvall, MD:
Thank you, Dr O'Brien, for having me.

Hope O'Brien, MD:
I'm so glad you're here. Headache is something that not too many people go into. And as a neurologist, what drew you to focus on this specialty?

Jaclyn Duvall, MD:
Well, it's so funny that you asked that because the truth is if you had asked me during my neurology residency if I would be a headache specialist, I might have laughed at you. I really did not have an interest in headache medicine. It wasn't until after residency that I was really in a general neurology practice and I absolutely fell in love with managing migraine. I found women that were in my very similar demographic with kids, busy careers, kind of in the throes of life, and it was really the ability to give them back days of their life that I just became so passionate about. I can recall a patient that I was seeing. She had been through a multitude of oral preventive medications and was still in the midst of chronic migraine.

So, as you know, chronic migraine, we have 15 or more headache days per month, at least eight migraine days per month. And she has two young kids at home. She was not really able to be present for them. She was really having a high burden of migraine on her life. We elected to pursue Botox, which at the time I was just new out of residency. I didn't know a lot about this. I had done some Botox training, but I hadn't really had the longitudinal or continuity of care with patients. And so, we elected to proceed with this treatment. I saw her back after her second round of injections and she was in

tears. I thought, oh no, another person with migraine that I'm not able to help. And it turned out that she was in tears of joy or gratitude. She said, Dr. Duvall, I didn't know how bad it was until I was playing with my son on the floor. And he looked at me and said, mom, you're playing with me. And I thought, gosh, that is what I want to do. I want to give people back days of their life.

Hope O'Brien, MD:
As a fellow headache specialist, as you're in this specialty, you see a lot of patients, you get more and more experience. Can you tell me what you wish you had learned prior to starting in this subspecialty?

Jaclyn Duvall, MD:
I think it's really important to keep in mind that we don't have a cure for migraine. And early on in my career in headache medicine, I really saw treatment failures as my personal failure. And then I would have patients who saw it as their personal failure. And so, I've really learned this concept of medications failed the patient and not the reverse, or they failed the provider. And I think it's understanding that there's not a one size fits all treatment for every patient we see, learning to reevaluate and to see patients across the course of their illness. What is working at one point in time may need to be adjusted or reassessed.

Hope O'Brien, MD:
And I like that you said not everybody responds to the same treatment and sort of this trial and error. How do you introduce that when talking about treatments to patients?

Jaclyn Duvall, MD:
I love introducing sort of the entire gamut of what we do. When I present migraine management, I tell our patients we have two arms of migraine management. They're equally important. I don't want you using just the left arm or just the right. I want you using these together. And then I go through the different classes of preventive medications. I think this is very important because as I know that we'll talk about, we do have step care within today's healthcare systems. And so, what I want people to know is sometimes when we're offering preventive medication, this might be because this is what your insurance company deems as your first choice. And for many individuals, that might be the right choice. But I want them to know that that's not necessarily the end of the road. We do have a lot of different treatments. Sometimes it looks like layering treatments together to find as much migraine freedom as we can.

Hope O'Brien, MD:
So, when staying on that treatment part of our discussion, can you talk about the goals of treatments and what can a patient expect in a medicine that is stopping their migraine attacks?

Jaclyn Duvall, MD:
Yes. So, we really have different goals of treatment when we're talking about acute versus preventive management of migraine. Our acute treatment goals are to provide rapid pain freedom and associated symptoms of migraine with little to no side effects that keeps the pain away so that patients can ideally

return to a function, return to their daily lives. On the other hand, preventive medicine and migraine, which is really what I hope we can talk more about today, is really focusing on reducing migraine frequency, severity and duration.

The American Headache Society says that a successful migraine preventive medicine is really providing at least 50% improvement. What I love in today's world of migraine management is that I think that's a lower bar. We do want to set expectations and recognize that these are not cures. But oftentimes we do see more than just this 50% improvement.

Hope O'Brien, MD:
I love what you said because it does set that expectation to a patient that what does good look like and kind of what are those goals. So, can you talk us through how you have that discussion to a patient on what to start with first?

Jaclyn Duvall, MD:
Yes. So, when we're talking about where to begin, sort of in our five classes of preventive medications, I'll walk through that we have our historical oral preventive medications. We utilize blood pressure medications, seizure medications, antidepressants. Oftentimes these are tailored to also look at comorbidities, so we have to question what medicines should a patient not be on because of various medical diagnoses. What medicine may help cover multiple things if someone is experiencing high blood pressure, could we manage that and also see improvement in migraine prevention. But oftentimes our historical medications are sort of burdened with side effects. And so that can be a really high issue. We know that many individuals, in fact up to 86% of them, discontinue preventive treatment within a year of starting it. And so, we have newer medications now that are more specifically aimed at migraine prevention. So, these medicines block a protein that's released when migraine happens and can really provide excellent efficacy for patients reducing frequency but also tend to have very high tolerability.

Hope O'Brien, MD:
You bring up a great point, and I think this is a great time to bring up the American Headache Society's Position Statement that talks about these newer therapies as being the first line that should be used in our patients with migraine.[1]

Jaclyn Duvall, MD:
That's right. I'm so thankful that this this position statement has come up, because I think it really helps us to show that as a community, as a headache community, we are advocating for our patients. In early 2024, this position statement was released. And it says patients should be able to access migraine specific prevention before having to step through medications that were not originally designed for migraine in the first place.

Hope O'Brien, MD:
Let's talk about what tools can we use to figure out whether or not what they're taking right now in terms of prevention is something that is working for them.

Jaclyn Duvall, MD:
This is so important because oftentimes, especially in primary care setting, I'll hear primary care providers tell me they don't want to poke the bear. They're almost afraid to ask. So, they just, is everything fine is a term that I often hear. And I think that that's really doing a disservice to our patients, because what does fine mean? I think that we really need to look at validated tools to assess migraine impact on day-to-day function. In our clinic, we use a scale that's called the MIDAS scale.[2] And so this is a degree of migraine's impact on day-to-day life. How am I making it to work? What about social functioning? What about household chores and kind of this impact that migraine can have.

What I also like to ask from a very practical standpoint is how many days of the month are you crystal clear pain free? Oftentimes, patients will come in trying to talk to us about their bad days, and we absolutely want to know about those bad, severe migraine days. But it's important to take a look at the entire burden of headache. And what we're learning more and more about is that migraine causes interictal burden as well. Patients fear the next attack. They live sort of on eggshells just waiting and wondering is it coming? Should I make plans or am I going to have to cancel and disappoint someone last minute? And so, I think if we can really ask patients what is the entire headache burden, it gives us a better idea of when to initiate preventive treatment.

Hope O'Brien, MD:
I think you bring up a point that a lot of patients, even if they're better, they don't talk about what that means. And we as providers may not know how to ask the question of what does better mean. So, in a patient who comes in and you are thinking that maybe they're not at their true goal, what kind of advice can you offer to providers to help patients open up and feel comfortable in talking about how do they get to that goal of four or less migraine days per month?

Jaclyn Duvall, MD:
I had a patient recently that I saw and she kept telling me, oh, I just have a few migraine days per month and I'm really fine is the term. But I got this sense based on just her demeanor with me that there was a bigger impact of migraine. And so, I rephrase the question. Instead of asking about headache days or even crystal-clear days, because I said, okay, so 27 days of the month, you're crystal clear? And she kind of nodded at me and I said, well, how is migraine impacting your life? Just a simple, straightforward question. And she started to tear up. She said, I actually really am not able to be present at work. She says she's calling out frequently. Even when she's at work, she's not functioning at her highest ability. And so, it was really evident in those questions that even though she was reporting low migraine frequency, that the burden and the impact of her day-to-day function was quite high.

Hope O'Brien, MD:
For a very busy primary care provider who may not have the time to, let's say, assess and figure out, okay, this treatment is working, are there any easy tools or ways to figure out from an acute standpoint if their acute medication is working?

Jaclyn Duvall, MD:
Yes. So, from an acute standpoint, the Migraine Treatment Optimization Questionnaire is really a simple screening tool that is asking do you feel comfortable enough utilizing your rescue treatment.[3] Basically, can you depend on it? Does just one dose stop the pain and keep it away? Does it take care of the associated symptoms? And do you have little or no side effects with this medication? So, these quick screening tools are very helpful especially in the primary care setting. And these are things that a patient could be sent home with even before their next appointment and asked to fill out maybe a week or so before coming back.

Hope O'Brien, MD:
That's great advice. So, let's say our primary care provider has done what they could do. They've given the acute treatments. They've given a preventive treatment. When would it be appropriate to then refer to a headache specialist?

Jaclyn Duvall, MD:
I always want to point out that if there is a primary care clinician that's finding that they aren't sure what to do, that's always the right time to refer. But I do think there are special circumstances where you can definitely say, okay, this is a patient that needs higher level of care. Of course, if someone's in the midst of chronic migraine, 15 or more days per month, I think that's an optimal patient, but also these more complicated cases. If someone is having aura that's really burdensome to them, or even these more challenging hemiplegic or basilar aura migraine, those are times to refer. And then if someone's ending up in ER or urgent care frequently, I think that also is sort of our red flag to say, okay, maybe they need a specialist.

Hope O'Brien, MD:
Now, we know that over time migraine can change and so patients can be well controlled for a while and then things can kind of worsen. So, what would you say to a primary care provider aside from referring them to a headache specialist, what can they do in their office?

Jaclyn Duvall, MD:
This is something that we'll see in migraine management, a condition we call tachyphylaxis, where maybe someone is doing well on a treatment and then over time it seems to lose efficacy. And we aren't exactly sure why this happens. Is there rewiring? Are there new neurotransmitters? Does a threshold change? There's lots of different ideas as to why this may happen, but in those situations, I recommend a change in treatment.

Oftentimes providers will think that, one, if let's say that they are on a migraine specific preventive medication, they'll think, okay, these are all the same class. I shouldn't switch between classes. But what we've learned is that actually that may not be the case. If I have one patient on a CRGP antagonist, I may switch to a different one. We may see efficacy again. Sometimes we'll even be on a drug holiday, reintroduce a medication, and you may see it work just like it did when we first started it. So, I suggest a change in treatment, really visiting new medications or even new classes of medications.

Hope O'Brien, MD:
I would agree with that. And the other piece, and what I also see too, is sometimes the patient isn't on the medication long enough. And so, setting up that expectation that sometimes it just takes some time for the medication to kick in and to not give up too early.

Jaclyn Duvall, MD:
Absolutely. And how often do we see patients that perhaps were not on a therapeutic dose of a medication. So, we really need to assess if they've taken it long enough to give it a chance, but also is the dosing right for that individual.

Hope O'Brien, MD:
In terms of accessing these newer medications for migraine, there can be some barriers to that. And so, can you talk about some of those barriers and how we can overcome them?

Jaclyn Duvall, MD:
Sure. So, I think the dreaded word in a healthcare setting is a prior authorization, I'll call the elephant in the room. But the truth is that most prior authorizations have been simplified within headache medicine, and it's really knowing a correct, accurate diagnosis, making sure that the boxes checked fit the FDA indication for the medication you're prescribing. So, I encourage clinicians that they need to make sure if they're prescribing an acute migraine medication, the diagnosis needs to be migraine, that can be with or without aura.

If we're looking at a preventive medication, looking at whether it's episodic or chronic migraine is tremendously important. And then making sure that the diagnosis matches your clinical documentation. So, I'll tell my medical assistants that I'm human. Sometimes I have errors within my chart note. If they're submitting a prior authorization for chronic migraine, and my notes are saying 5 headache days per month, they come to ask me and say, Dr. Duvall, are you sure that that this is chronic migraine? We've sort of educated them on the diagnosis. I say, oh no, I missed a 1. That's 15 headache days that this individual is having. But I'm human and this happens in my notes. So, we need to make sure that the chart notes match up with what we're documenting in the authorization.

Hope O'Brien, MD:
Now, there's a lot of treatment options out there and we talked about some of the acute, preventive medication. Are there other therapies that can be used as well, especially in patients who may not want to take a pharmacological medication?

Jaclyn Duvall, MD:
Absolutely. I mean, so I think when we look at an individual living with migraine, we first went to assess lifestyle changes. We're looking at sleep quality. We're looking at caffeine intake, dietary factors, really things that are pro-inflammatory. So really kind of getting back to the basics. We can look at supplements. Oftentimes individuals are interested in which supplements might be beneficial for prevention. We have nerve stimulator devices available now. So, we have really a multitude of different

treatments. In fact, I know the Migraine World Summit recently published 100 lifestyle interventions that you can do for migraine. And so I was kind of peeking through those and just different advice that people can use: a migraine cap that you can use that can help with heat if somebody is heat intolerant, different earplugs if you're having a lot of noise sensitivity, we have a light reflecting glasses that can be helpful, FL-41 lenses. So, there are a number of non-pharmacological measures that can be taken.

Hope O'Brien, MD:
So, there's a lot of information out there and with the internet, patients will just do the Doctor Google and come in with all sorts of information. Are there resources that you would recommend that providers or patients go to where they can get trusted information?

Jaclyn Duvall, MD:
Absolutely. And I really encourage individuals to look for these trusted sites. It can get overwhelming even as a headache specialist where this is my entire world, it can be overwhelming to go, how much of this can I trust or rely on? And so, I really do want to emphasize the National Headache Foundation has free CME for especially in the primary care setting, so there is Primary Care Migraine.[4] You can go to headaches.org in the provider section to access this. We put out a newsletter for primary care as well that can be tremendously helpful for them.

Hope O'Brien, MD:
Well, this has been an amazing discussion. Thank you so much Dr. Duvall for sharing your insights on managing headache disorders over time, and for helping providers better understand how to evaluate, adjust, and optimize care. Thank you to our listeners for joining us. We hope this episode gives you practical strategies to improve long-term outcomes for patients.

For your patients, we've created a companion Patient Series that will help your patients recognize symptoms, communicate clearly, and come prepared for visits. For the full series, go to headaches.org . I thank you again for listening. Until next time.

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[1] American Headache Society's Position Statements https://headaches.org/insurance-pharmacy-coverage/ahs-position-statements
[2] MIDAS https://headaches.org/resources/headache-tests
[3] Migraine Treatment Optimization Questionnaire (mTOQ-4) https://headaches.org/patient-access/successful-encounters-with-my-provider
[4] National Headache Foundation's Primary Care Migraine CME https://www.pcmigraine.org