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

Novel and Emerging Chronic Migraine Therapies

Announcer:
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Dr. Tepper:
Hello, I'm Stewart Tepper. I'm a Professor of Neurology at the Geisel School of Medicine at Dartmouth, and Vice President of the New England Institute for Neurology and Headache in Stamford, Connecticut. I'm going to talk to you about novel and emerging chronic migraine therapies.

The FDA has approved or cleared the following for chronic migraine prevention. The medicines that are approved for chronic migraine include onabotulinum toxin A, erenumab, an anti-CGRP receptor monoclonal antibody, 3 anti-CGRP ligand monoclonal antibodies, fremanezumab, galcanezumab, and eptinezumab, and atogepant, a small molecule CGRP receptor antagonist, or gepant. These medicines work primarily peripherally in the meninges, for the most part on the migraine pain mechanisms.

The chronic migraine preventive target that has proved to be most useful is calcitonin gene-related peptide, or CGRP. And it's represented by the small blue spheres in the center here which are released through a vesicular fusion presynaptically. Onabotulinum toxin A prevents that the vesicular fusion and thereby prevents CGRP release. Erenumab is anti-CGRP receptor monoclonal antibody binding to the G protein coupled transmembrane postsynaptic receptor. The anti-CGRP ligand monoclonal antibodies, galcanezumab, fremanezumab, and eptinezumab bind to the CGRP ligand itself and prevent the CGRP from binding. And finally, the gepant, atogepant, is a small molecule which sits in the CGRP receptor, preventing the CGRP from binding and through - and when the receptor is activated through a cyclic AMP mechanism, it would cause neurogenic inflammation and vasodilation, prevented by these medications.

This has resulted in big changes in our treatment. The old treatment paradigm was to hold off on prevention until we were forced to prescribe because of migraine severe disability, high frequency episodes, increasing use of medications, and risk for transformation to chronic migraine and medication overuse headache. And we had to prescribe nonspecific oral preventive medicines and try to get a 2 for 1, in which we'd combine nonspecific treatment for migraine and comorbid illnesses. We would plan a wean of overused acute medicines and live with suboptimal responses in our patients for efficacy with resultant lack of adherence. And we measured effectiveness by reduction in mean monthly migraine days.

In the new paradigm and the new day, cost/benefit analysis changes due to the high efficacy, tolerability, and safety of the migraine preventive therapies have allowed us to use them early, based on disability or impact. And we can use optimal treatments separately for the comorbid illness and for the chronic migraine. And we simply prevent - prescribe the prevention and allow the acute medication to use to - the acute medication use to gradually subside. Monoclonal antibodies are superior to the older nonspecific preventive treatments for efficacy, side effects, in placebo-subtracted analyses, direct comparison, onset of effect, responder rates, they work and people who have had at least 2 to 4 previous preventive medicines fail, and they convert chronic migraine to episodic migraine, out of medication overuse, they improve adherence, and they allow specific targeted treatment for comorbid illness, improving the interictal

burden of disease.

These are the chronic migraine preventive medicines: onabotulinumtoxinA at 155 units given in the PREEMPT protocol quarterly, erenumab 70 or 140 mg autoinjector monthly, fremanezumab 225 mg quarterly with an autoinjector or prefilled syringe, galcanezumab with a 240-mg loading dose, and 120 mg sub-q by autoinjector or prefilled syringe, eptinezumab with 100 mg or 300 mg IV given quarterly, and atogepant, a 60-mg tablet given daily.

So in summary, targeting CGRP has resulted in 2 new classes of chronic migraine prevention, monoclonal antibodies and gepants. And 4 monoclonal antibodies and 1 gepant are FDA approved for chronic migraine prevention. The newer treatments are better tolerated, safer, and more effective than the nonspecific migraine preventive treatments of the old days. The older treatments are not even specifically FDA approved for chronic migraine prevention. The older nonspecific preventive treatments and the non-invasive neuromodulation devices prevent migraine centrally while onabotulinumtoxinA and the new anti-CGRP treatments have predominant peripheral preventive effects.

Thank you, and I hope you are able to take this information and change the paradigm of your treatment for chronic migraine.

Announcer:
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