

COMMENTARY

Advocacy for Female Migraineurs

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I am a private practice neurologist who has practiced out-patient headache medicine exclusively for the past 10 years. Ninety percent of our patients have migraine, and over 80% are women. Migraine population-based, epidemiologic research has shown that migraine is three times more likely to occur in women than men, and over 1 billion people worldwide have migraine. Among females aged 15-49 migraine is the top cause of disability globally.¹ Unfortunately, these women have received little attention in global health policy debates.² The World Health Organization has issued a “gender challenge”, and a new field of scientific investigation has evolved - so-called gender medicine, which has concluded that the migraine gender difference is explained by hormonal effects, different reactions to pain, and structural and functional differences in the brain.³

Neurology, once considered a “diagnose and adios” specialty, is gaining newfound scientific respect. Our vastly improved understanding of migraine diagnoses and pathophysiology has led to many Food and Drug Administration-approved medications that can specifically enhance treatment outcomes. These medications for migraine have been extended and modernized: for millions of women, these medicines fulfill their long-awaited needs.

Daily, I evaluate and treat challenging, severely disabled female migraine patients who require hours of time beyond the physical examination. I pour over previous medical records and focus on conversations with them to glean diagnostic and treatment perspectives in the hope of developing a stratified treatment approach which involves matching the treatment intensity to the level of complexity in each migraine patient with the goal of meeting their unique, unmet treatment needs. I have yet to evaluate a migraine patient who wholly mirrors another. Effective migraine care, I believe, is not the result of any disease-dependent intellectual exercise, but rather a lifelong effort to help a patient gain control over her circumstance. When appropriate, I discuss with patients the new acute and preventive anti-calcitonin gene-related peptide medications, which, for the chronic migraine patient, can be a small slice of heaven. Reality strikes, however, when we discuss the likely prior authorization (PA) process. This conversation no longer shifts on getting likely migraine relief, but instead on the insurance company

approving the PA. This utilization-management requirement is primarily utilized to contain prescription-drug expenditures and most often requires stepped care mandating patients try a lower-cost medication before stepping-up to a more expensive drug. This balancing act approach to improve quality of care and contain costs appears to be limited especially in more complex patients.^{4,5} Stratification of care instead of step care treatment strategies for migraine patients enables us to promptly prescribe more effective treatments without the considerable, unconscionable delay secondary to onerous PA processes that frequently mitigate patient centric care and patient outcomes.^{6,7} As Sir William Osler expressed years ago, “The good physician treats the disease; the great physician treats the patient who has the disease.”

Health insurance companies and many others should realize that migraine is not just a headache, as well as the importance of destigmatizing the condition. I have personally witnessed the ostracization and isolation that innumerable women with migraine incessantly experience because of discriminatory judgement and marginalization. Because migraine is considerably more prevalent in women, this disease remains perceived by many as a “female illness” and, therefore, less legitimate. Sadly, perception frequently drives reality, and it is our responsibility as healthcare providers to change the mindset of many from opinion-based decisions entrenched in ignorance, compassion fatigue, or suboptimal economic standards, to evidence-based, centered on our present knowledge and future migraine advancements. Increasing awareness and legitimizing migraine not as a weakness but instead as a justifiably painful and disabling disease – not unlike osteoarthritis and endometriosis - will potentially help destigmatize migraine and encourage women with migraine to openly and candidly discuss it and seek treatment.

These women are frequently strong, intelligent, creative people who are desperate to find a healthcare provider who will actively listen to their migraine journey and consider optimizing their treatment. These treatments primarily include nonpharmacologic, pharmacologic, and neuromodulatory interventions - and the good news is that, since the early '90s, the burgeoning migraine treatment armamentarium continues to evolve and flourish.⁸ Considering the heavy female burden of migraine and that most of these women are within their child-bearing, educational, and working years, migraines strongly impact not only their physical health but also their psychological well-being, productivity, and quality of life. Recognizing the singularity of each patient and keeping the patient in the center with a shared decision-making model of care can and frequently does result in a happy, content lady who is in control of her migraines instead of them controlling her.⁹

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