

Critical Issues in Migraine Management at Managed Care Organizations

This Special Report supplement to *The American Journal of Managed Care* provides highlights from three symposia on migraine management and managed care issues. These symposia were held in: Colorado Springs, Colorado, May 15-16, 1998; Arlington, Virginia, May 29-30, 1998; and Kansas City, Missouri, June 5-6, 1998.

Migraine is a common condition, more prevalent than multiple sclerosis, Alzheimer's disease, epilepsy, stroke, and Parkinson's disease. Apart from impairing patients' quality of life, it results in direct and indirect costs that total billions of dollars every year in the United States alone.

The presentations and roundtable discussions present an overview of the etiology, pharmacologic treatment, individual impact, and economic impact of migraine and a discussion of how triptans (eg, sumatriptan [Imitrex], zolmitriptan [Zomig]) should be used in treating migraine. Also addressed is the question of how to provide cost-effective migraine management at managed care organizations.

Pharmacologic methods of treating migraine can be classified into two groups: prophylactic and abortive. Prophylactic medications are used for patients with frequent migraine headaches

or for patients in whom abortive medications are ineffective or contraindicated. The first triptan for abortive therapy, injectable sumatriptan, was introduced in the United States in 1993; oral and intranasal formulations followed. Triptans brought onto the market since 1993 include oral zolmitriptan and oral naratriptan (Amerge); rizatriptan (Maxalt) was introduced in mid-1998. Injectable sumatriptan is fast and efficacious; however, it is expensive compared with the intranasal and oral formulations. Companies develop new triptans in the hope of creating drugs with a faster onset of action, fewer adverse effects, and a lower headache recurrence rate. These drugs might result in reduced costs.

Migraine is a common condition, more prevalent than multiple sclerosis, Alzheimer's disease, epilepsy, stroke, and Parkinson's disease. Apart from impairing patients' quality of life, it results in direct and indirect costs that total billions of dollars every year in the United States alone. The direct costs include doctor visits, diagnostic tests, use of pharmacy services, visits to urgent care centers and emergency rooms, and hospitalization. Indirect costs include decreased productivity and absences from work or school.

The second presentation at the Arlington, Virginia, symposium was made by Nabih M. Ramadan, MD, Director of the Cincinnati Headache Center and Associate Professor of Neurology at the Department of Neurology, University of Cincinnati. He addressed the etiology and impact of migraine disorder, non-pharmacologic and pharmacologic

means of treating migraine, old and new abortive therapies, prophylactic therapy, and the stepwise versus the stratified approach to treatment. He made a strong case for stratified care as opposed to stepped care (across attacks) and staged care (within attacks). Stepped care and staged care both involve starting the patient with one medication and moving to another medication if the first one is ineffective. Stepped care may involve several medications in sequence. Stratified care is individualized treatment based on the characteristics of the patient's headache, the patient's level of disability, and any contraindications or precautions related to therapy.

Another presentation at the Arlington, Virginia, symposium was made by Jeffrey P. Trotter, President of ClinTrials Ovation, Inc., in Highland Park, Illinois. He focused on the economic burden of migraine and the possible economic consequences of triptans being efficacious. With effective migraine medications, managed care organizations can have lower costs and increased patient satisfaction, he noted. Mr. Trotter said that a stratified approach to treatment was important.

In his presentation at the Colorado Springs, Colorado, symposium, James U. Adelman, MD, Clinical Associate Professor, Department of Neurology, University of North Carolina Medical School, said that the treatment of headaches is getting better and better. He discussed the process of diagnosis and outlined the characteristics of primary headache (tension, cluster, and migraine). Good communication between patient and doctor is essential for effective migraine treatment, he said. Patients must provide information about the characteristics of their headaches and their triggers; in turn, the doctor should provide patient education. Dr. Adelman noted that a large majority of migraine patients have migraine once a week or less, and acute care medications are appropriate in these patients. He also stated that stratified care is preferable to stepped care in migraine patients.

In her presentation at the Colorado Springs, Colorado, symposium, Mary Glenn Vreeland, MHA, RRA, Manager at ClinTrials Ovation, Inc., in Highland Park, Illinois, noted that the economic and clinical burden of migraine is substantial. Furthermore, migraine is underdiagnosed. However, even those patients in whom migraine is undiagnosed and incorrectly treated still incur costs and utilize resources. Ms. Vreeland noted that the development of triptans has been tremendously beneficial, resulting in fewer physician and urgent care visits, an improved quality of life for patients, and lower indirect costs associated with migraine.

Les L. Noe, MPA, RPh, Senior Manager at ClinTrials Ovation, Inc., in Highland Park, Illinois, in his presentation at the symposium in Kansas City, Missouri, made the point that there is a cost savings with zolmitriptan compared

ACRONYM LIST

The following acronyms appear in the pages of this Special Report supplement:

AAN	American Academy of Neurology
ANA	antinuclear antibody
CAT	computed axial tomography
CNS	central nervous system
DHE	dihydroergotamine
EEG	electroencephalogram
ET	ergotamine
FDA	Food and Drug Administration
HDI	Henry Ford Hospital Headache Disability Inventory
HIV	human immunodeficiency virus
ICD-9	<i>International Classification of Diseases, 9th Revision</i>
IHS	International Headache Society
MIDAS	migraine disability assessment
MRI	magnetic resonance spectroscopy
NSAID	nonsteroidal anti-inflammatory drug
SSRI	selective serotonin reuptake inhibitor
TMJ	temporomandibular joint
VDRL	venereal disease research laboratory

with sumatriptan even without measuring indirect costs or costs of comorbid conditions.

Faculty question-and-answer sessions in Arlington, Virginia, and Kansas City, Missouri, gave symposium participants the chance to ask questions about migraine diagnosis and management. Dr. Ramadan noted that neither primary care physicians nor neurologists always diagnose migraine correctly, according to International Headache Society (IHS) criteria. Both the Henry Ford Hospital Headache Disability Inventory (HDI) and the migraine disability assessment (MIDAS) scale are useful tools for determining how disabling the condition is, he said.

Dr. Ramadan made the point that there is a place in migraine therapy for a variety of medications, from over-the-counter medicines to the triptans. Dr. Adelman also made the point that only a minority of migraineurs have aura with their headaches and that not all migraine headaches fit the picture of a "typical" migraine.

The importance of stratified care was stressed by all faculty participants in these symposia. Stratified care involves treating the headache on the basis of the patient's disability, the characteristics of the headache, the history of the headache, and any contraindications or precautions. This care, which also involves patient education, is individualized from the beginning.