Take 3 – Practical Practice Pointers© January 21, 2019 Edition

New Migraine Treatments, Best Diets 2019, Statins in the Elderly

Position Statement From the American Headache Society (AHS)

1) Integrating New Migraine Treatments Into Clinical Practice

Migraine is characterized by attacks of throbbing, often unilateral headache that are exacerbated by physical activity and associated with photophobia, phonophobia, nausea, and vomiting. About one third of patients have migraine with an aura and three quarters experience a premonitory phase prior to the onset of headache. Diagnoses of migraine can be refined based on the frequency of monthly migraine days (MMDs) and monthly headache days (MHDs); patients with fewer than 15 MMDs or MHDs have episodic migraine, and those with at least 15 MHDs, of which at least 8 are MMDs, have chronic migraine. The American Headache Society recently published a position statement on integrating new migraine treatments into clinical practice.

All patients with migraine should be offered a trial of **acute treatment**. Use NSAIDs (including aspirin), nonopioid analgesics, acetaminophen, or caffeinated analgesic combinations (eg, aspirin + acetaminophen + caffeine) for mild-to-moderate attacks and migraine-specific agents (triptans, dihydroergotamine [DHE]) for moderate or severe attacks and mild-to-moderate attacks that respond poorly to other agents. Opioids also have established efficacy for acute treatment. Nonoral routes of administration should be considered in patients who do not respond well to oral treatments.

Patients should be instructed to limit treatment to an average of 2 headache days per week, and those exceeding this should be offered preventive treatment. Patients who have medication overuse despite the use of preventive treatment may require an escalation in dose, a change in preventive therapy, or the addition of another agent.

Emerging agents for acute treatment include the small molecule CGRP receptor antagonists, ubrogepant and rimegepant, and lasmiditan, a selective serotonin ($5\text{-}HT_{1F}$) receptor agonist. These novel treatment options do not constrict blood vessels and may have a special role for those with cardiovascular contraindications to triptans. Patients who have contraindications to the use of triptans or who have failed to respond to or tolerate at least 2 oral triptans are eligible for these agents or a neuromodulation device.

Several noninvasive devices have been developed that modulate pain mechanisms by stimulating the nervous system centrally or peripherally with an electric current or a magnetic field. These include single-pulse transcranial magnetic stimulation for the acute and preventive treatment of migraine, electrical trigeminal nerve stimulation for the acute and preventive treatment of migraine, and noninvasive vagus nerve stimulation for the acute treatment of migraine. Patients who prefer nondrug therapies and those who have failed to respond to, have contraindications to, or poor tolerability with pharmacotherapy may be candidates for neuromodulation.

Many oral **preventive treatments** have limited to moderate efficacy, moderate to high rates of adverse events (AEs), contraindications, or interactions that limit use. Few use preventive treatment (3–13%), even though it is believed that nearly 40% of those with episodic migraine, and almost all of those with chronic migraine, would benefit.

Preventive treatment should be considered in any of the following situations: attacks significantly interfering with daily routines despite acute treatment; frequent attacks (≥4 MHDs); patient preference; contraindication to, failure, or overuse of acute treatments, with overuse defined as:

- 10 or more days per month for ergot derivatives, triptans, opioids, combination analgesics, and a combination of drugs from different classes that are not individually overused
- 15 or more days per month for nonopioid analgesics, acetaminophen, and nonsteroidal antiinflammatory drugs (NSAIDs [including aspirin])

The following oral treatments have established efficacy and should be offered for migraine prevention: antiepileptic drugs (divalproex sodium, valproate sodium, topiramate); beta-blockers (metoprolol, propranolol, timolol); and frovatriptan (for short-term preventive treatment of menstrual migraine). Valproate sodium and topiramate should be used with caution with women of childbearing potential. The following treatments are probably effective and should be considered for migraine prevention: antidepressants (amitriptyline, venlafaxine); beta-blockers (atenolol, nadolol); and angiotensin receptor blockers (candesartan).

There are 4 injectable preventive therapies for migraine: onabotulinumtoxinA and 3 monoclonal antibodies (mAbs) (fremanezumab, galcanezumab, erenumab). OnabotulinumtoxinA is approved for chronic migraine, and erenumab, fremanezumab, and galcanezumab are approved for episodic and chronic migraine. These agents have favorable tolerability profiles. Indications include inability to tolerate or inadequate response to a 6-week trial of at least 2 of the oral medications listed above.

In general, a significant reduction (eg, 50%) in MHDs is a useful benchmark for effectiveness in practice. Additionally, patient-centric and validated outcome measures that evaluate the effect of treatment on functional capacity, disability, and quality of life are important for determining whether meaningful change has occurred.

Education and lifestyle modification is important in the management of migraine. Minimizing exposure and managing unavoidable triggers, appropriate and individualized nutrition advice, and exercise should be implemented and personalized for each patient. Biobehavioral therapy, including cognitive behavioral therapy (CBT) and biofeedback, and relaxation therapies have been shown to be effective in the acute and preventive treatment of migraine. Evidence suggests that combining biobehavioral interventions with pharmacotherapy provides greater benefits than either modality alone.

My Comment:
I thought this article provided a nice review of present therapies. Needless to say, these new novel pharmacologic agents come with a steep price tag. I'm struck by how few patients who might benefit from prophylactic therapy are actually using it. Perhaps that's a wiser place to focus treatment. For those who receive the American Family Physician journal, there's also a nice review of this in the January 1st edition.

Reference:
The American Headache Society Position Statement On Integrating New Migraine Treatments Into Clinical Practice. Headache. 2019 Jan;59(1):1-18. Article

From the US News and World Report

2) Best Diet Rankings for 2019

U.S. News recently released its annual assessment of the best diets, offering extensive data and information on 41 popular diet plans. The rankings were established by a panel of experts, including nutritionists, dieticians and physicians. They evaluated and scored the diets in seven areas, including: how easy it is to follow; likelihood of losing significant weight in the first 12 months; likelihood of losing significant weight for 2 years or more; how well it helps prevent and manage cardiovascular disease; how well it helps prevent and manage diabetes; nutritional completeness; and safety.

For the second consecutive year, the Mediterranean Diet ranks as the No. 1 Best Diet Overall. The Mediterranean Diet also rated best in multiple other categories: Easiest Diets to Follow, Best Diets for Healthy Eating, Best Diets for Diabetes, and Best Diets for Heart Health (tie). The DASH Diet was rated the No. 2 best overall diet. The Flexitarian Diet (a plant-based plan, with meat in moderation) was 3rd overall, followed by WW (Weight Watchers) and the MIND Diet tied for fourth. The MIND diet combines part of the DASH and Mediterranean plans and aims to boost brain health.

WW (Weight Watchers) was the top rated Best Weight-Loss Diet and Best Commercial Diet. Jenny Craig was the 2nd Best Commercial Diet, followed by the Nutritarian Diet.

It is important to note that there isn't "a" Mediterranean diet. The lifestyle of people in countries bordering the Mediterranean Sea shares common principles, including an active lifestyle, weight control, and a diet high in produce, nuts and healthy oils and low in red meat, sugar, and saturated fat. A Mediterranean diet pyramid has been developed to help serve as a guide for this nutritional approach (see References).

The DASH Diet (Dietary Approaches to Stop Hypertension) is promoted by the NHLBI to stop or prevent HTN. It emphasizes vegetables, fruits, whole grains, lean protein and low-fat dairy. DASH also discourages foods that are high in saturated fat, such as fatty meats, full-fat dairy foods and tropical oils, as well as sugar-sweetened beverages and sweets and sodium. The NHLBI publishes free guides on the plan (See references).

Among the diet plans that ranked much lower: Atkins, Keto, Whole 30, Body Reset, and Dukan Diets. Most of these include a limitation of carbs and an emphasis on protein.

My Comment:
I asked Beth Polk, MD, one of our FM colleagues who is board certified in Lifestyle Medicine and also is faculty for the AAFP Family Physician Health and Well-being Conference to provide commentary. Beth replied, *"What stands out for me is that there is a growing consensus that a diet that consists of predominantly plants is the healthiest overall and addresses most of the chronic diseases we see every day. Increasing fruits, vegetables, beans, nuts and seeds, decreasing meat intake and eliminating processed foods is the common thread in the top diets mentioned. The best advice we are able to give our patients is still 'eat food, mostly plants, and not too much.'"*

This is the approach I follow personally. I've named it the "Pollenian diet" after the author Michael Pollen, who described this approach in his book In Defense of Food.

References:

- U.S. News Reveals Best Diets Rankings for 2019. January 2, 2019. Article
- Oldways Mediterranean Diet: Link and Diet Pyramid: Pyramid Link
- DASH Information long version: Link and short version: Link

A Question from a Colleague

3) Statin Use in the Elderly

Question:
The new recommendations from the ACC/AHA regarding statin use for primary prevention for CVD only go up to age 75. What about those older than 75?

Answer:
Cardiovascular events are the leading cause of morbidity and mortality in adults aged 75 and older, with coronary heart disease (CHD) and stroke accounting for 60% of deaths in those aged 85 and older. The new ACC/AHA guidelines focus on persons between the ages of 40 – 75. The risk calculator does not extend beyond age 75, though for secondary prevention (known ASCVD) and for statin use for patients with DM, the recommendations extend beyond age 75.

As for primary prevention, a recent article sought to address this. The National Institute on Aging and the National Heart, Lung and Blood Institute convened a multidisciplinary expert panel to review existing evidence to determine the efficacy and safety of statins for primary prevention of ASCVD events in adults aged 75 and older, especially those aged 80 and older and with multimorbidity.

The review concluded there is insufficient evidence as to the benefits and harms of statins in older adults, a lack of tools to assess ASCVD risk in those $\geq$ 80, and a paucity of evidence of the effect of statins on outcomes of importance to older adults, such as statin-associated muscle symptoms, cognitive function, and incident T2D.

My Comment:
I reached out to two of my FM colleagues, Brian Unwin, MD, who is the Section Chief for Geriatric Medicine at Carilion Clinic, and Aubrey Knight, MD, who is the Fellowship Director for our Carilion Clinic Geriatrics fellowship. Their answers were consistent and build upon each other. Dr. Unwin indicated*, "I think clinicians have more important things to do like addressing frailty, cognitive impairment, polypharmacy, and multiple co-morbidity issues. Primary prevention of ASCVD in late life takes the last seat on the things I will address."* Dr. Knight added*, "My experience has been that patients and families are reluctant to stop statins because we have done such a good job in convincing them of the value up until the point at which that value is now limited at best. My approach has been to talk in terms of life expectancy and the potential for benefit which places this question squarely into a shared decision-making proposition."*

As with much in medicine, context is important, and context becomes even more important in the "4th quarter" of life. For many, particularly when looked at statistically, primary prevention of ASCVD likely should be a low priority.

Reference:
Singh S, et al. Statins for Primary Prevention in Older Adults. J. Am Geriatr Soc. 2018 Nov;66(11):2188-2196. Abstract Article

Feel free to forward Take 3 to your colleagues. Glad to add them to the distribution list.

Mark

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