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COMMENTARY

"Triaging" Chronic Migraine Patients in Need of CGRP(r) Monoclonal Antibodies

Paolo Martelletti

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Key Summary Points

Chronic migraine is a neurological disorder associated with a highly disabling and burdensome form of pain.

The management of chronic migraine must be allocated to the appropriate healthcare professionals.

Monoclonal antibodies against CGRP(r) should initially be reserved for the treatment of patients with pre-chronic migraine in order to reduce the economic impact to healthcare systems.

The social relevance of headache and headache-related disability is evidenced by the enormity of the impact of this group of non-communicable diseases on epidemiology, progressive disability to the patient, and the direct and indirect costs that must be borne by both healthcare systems and patients [1–8].

Chronic migraine patients, in particular, are not always correctly diagnosed within an acceptable time frame or adequately treated. Thus, the patient, who may not be properly informed on the use of medications and the correct pharmalogical treatment, may opt for an uncontrolled self-medication regimen, often ending up in an Emergency Department with a completely different life-threatening condition [9–12].

The need to involve general practitioners in the management of low-frequency migraine is a clear priority in healthcare systems and would free tertiary-level headache centers from treating progressive and complicated forms of medication overuse [13]. This change in the approach to the treatment of low-frequency migraine is particularly important now that sufferers of high-frequency or chronic migraine need hospital access to be treated with a new pharmacological class of medications—monoclonal antibodies to calcitonin gene-related peptide (CGRP) or its receptor (CGRPr). Studies conducted on this pharmacological class of medications report clear evidence of a high efficacy, as well as associated high treatment costs [14–16].

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A3 P. Martelletti (✉)
A4 Department of Clinical and Molecular Medicine,
A5 Sapienza University, Rome, Italy
A6 e-mail: paolo.martelletti@uniroma1.it

However, just how to identify those migraine patients in need of these new therapies with monoclonal antibodies is a matter still being debated and prioritized. The parameters for selecting these patients need to be very precise and based on a uniformity applied by all specialists treating chronic migraine, neurologists, pain physicians, Emergency Room specialists, and internal medicine specialists. An explicit aim, hopefully applicable on a large scale, is to identify early in the treatment trajectory those patients with a frequency of migraine crisis rapidly progressing towards chronicity that may, in the future, evolve into chronic forms and represent the hard core of refractoriness [17]. These are the patients who show fluctuations in the pre-chronic phase, with a high frequency of migraine crises, but who have not progressed to the stable chronic stage [18]. At the same time, it is very important to resolutely limit the creeping trend of expanding the targets of this new pharmacological class of medications by also including patients with high-frequency migraine in the definition of chronicity [19]. Such an inclusion would rapidly stress the spending sustainability of national health systems in general and also specifically penalize patients with chronic and pre-chronic migraine who have failed previous preventive therapies and who need priority access to these new treatments.

Through redefining the progression of the disease into chronicity with this new class of drugs, defined as *disease-modifying migraine drugs* (DMMDs), a significant reduction in public healthcare system expenditures can be achieved [20]. This highlights the importance of appropriately "triaging" migraine patients, with interventional priority on the interception of high-frequency patients who fluctuate in and out of the chronic migraine phase.

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