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What's New in Migraine Prevention? Understanding the 2026 AAN/AHS Guidelines

[00:00:00] **Billy:** Uh, welcome Dr. Blumenfeld. Um, may I ask you to please introduce yourself?

[00:00:07] **Dr. Blumenfeld:** Sure. My name's Andrew Blumenfeld. I'm a neurologist and I work at Cedars-Sinai in Los Angeles .

[00:00:15] **Billy:** So the AAN and AHS have released the first major update to migraine prevention guidance since 2012.

[00:00:22] Uh, from a practicing neurologist perspective, what are the most important changes in these guidelines, and what should neurologists do differently as a result?

[00:00:30] **Dr. Blumenfeld:** Yeah, and it's interesting. You know, the, the guidelines that we had previously are 14 years old, and those guidelines focused on a listing of medications and focused mainly on efficacy. Um, tolerability and sort of patient preference issues did not come into the guideline. It looked at levels of evidence that focused specifically on reduction of migraine days, uh, in terms of [00:01:00] prevention treatments.

[00:01:02] What this guideline does that is quite different, it really takes into account your interaction with the patient, and it looks at all the variables that would happen during that visit and how you'd be talking to the patient to make treatment decisions. So it focuses very strongly on a shared decision-making process for picking the right treatment for an individual patient.

[00:01:28] And, and which is, is very good. It really focuses down on individualized care. So you would be talking to a patient and finding out what are their main concerns with the treatments you're offering. And if, for example, their main concern is efficacy, the guideline then gives you the best choices for efficacy.

[00:01:51] If their main concern is tolerability or long-term use, something that's been around for a long time, and if that was their main [00:02:00] question, then it gives you that option to, to plug in and use the guideline to answer that question, and it gives you the evidence for it. And so it's a, it's a very useful tool, um, and a completely different approach to what we've dealt with before.

[00:02:18] Very comprehensive way of thinking about it. And so instead of just being a guideline that, that looks at individual medicines and says, "Oh, this is good because it's separated from placebo," it's really walking you through all your decision-making with a patient. And I could see it having influence even at a follow-up visit where you've now prescribed something, the patient comes back and says, "Well, you know, that worked.

[00:02:45] I liked it, but there were side effects, so I really want something that doesn't have side effects." And now you'd be able to go to that, um, option. And, and it does this even for the comorbid conditions. It looks, for example, at a [00:03:00] pregnancy or high BMI. And says, "Okay, these are the things you could think about if you wanna hit these, uh, conditions, um, a- as well."

[00:03:10] Fibromyalgia is listed a- as one of those. So it, it was very thoughtfully done. Uh, and, and I really appreciate the effort that went into this, and I think it's an excellent tool that has been developed.

[00:03:25] **Billy:** That's sort of something we're seeing across neurology and, and, and medicine, isn't it? Like, a more personalized care and, and a more comprehensive view of what care means, right?

[00:03:37] **Dr. Blumenfeld:** Correct. But we've, we haven't had a guideline that really walked through each of the variables like this does. The only criticism I'd have is that at first read it can be quite difficult 'cause you, you, you're reading through all these sort of variables, trying to grasp the direction. I think it would've been nice if they had done a table [00:04:00] that listed all the variables that go into the shared decision-making discussion, and then had all the medicines across the top, and then maybe had boxes, you know, that were

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green for good and red for bad.

[00:04:14] And then at, at a glance, it would be a very useful tool. Uh, and I think that could still be done as a, as a way of optimizing it and making it just m- more user-friendly.

[00:04:26] **Billy:** Yeah, definitely. That does sound like it would be a easy at-a-glance, um, way to look at the information. And, and also speaking of, of medicines, there, there are so many new therapies, you know, with, such as CRGP targeting therapies, other, um, newer options, as well as more established treatments like topiramate and BOTOX.

[00:04:46] So how should clinicians navigate these, all these different options to determine which preventive treatment is the best starting point for one of their patients?

[00:04:55] **Dr. Blumenfeld:** Well, most patients are gonna focus on efficacy and tolerability. [00:05:00] That's, that part of the guideline is where you're really going to maximize the use of it.

[00:05:06] And what's really good about this guideline is that it, it takes into account the position statement that the American Headache Society came out with a few years ago, which basically said we should use migraine-specific treatments as a first line, that we shouldn't be doing a lot of step treatments and going through non-specific treatments.

[00:05:32] And it also, in this guideline, for the first time, talks about preventing patients from transforming from episodic migraine, the low frequency, to a chronic migraine state, the high frequency state. And the, the, the point there is that you need to start an effective preventative treatment as early as possible in the course [00:06:00] of the patient's life to prevent this transformation.

[00:06:04] So that's a very important point that's, that's been highlighted in the guideline. And It pushes us to think about the anti-CGRP medications much quicker. And, uh, when, when it's listed in this guideline, they list each medicine under each of the, the shared decision-making variables, um, in an alphabetical way.

[00:06:28] And they basically say, "This group is what we recommend." So you'll see under efficacy, atogepant, and then you'll see the monoclonal antibodies listed, um, you know, all four of them, as good options, um, for efficacy. And, uh, and, and it's similarly done, you know, for tolerability. Um, again, it'll list, um, the ones that high, have high tolerability, and the [00:07:00] anti-CGRP drugs in, in general do have very good tolerability.

[00:07:05] Um, and, and in, in my practice, I'm actually looking at both of those. So even if a patient says to me, "I want efficacy," I'm gonna say, "That's great, but the point is, if you don't tolerate it, you're not gonna see the efficacy." So I'm gonna look at the efficacy box, and then I'm also gonna look at the tolerability box, and then I'm gonna find the drug that crosses both of those and say, "Okay, this is the one that I think is gonna work for you."

[00:07:35] And again, under that tolerability box, I'm going to find a similar list. But topiramate and propanolol, which might score in the efficacy box, are gonna disappear in the tolerability box. And so a nice way of thinking about this is to have an effective treatment for a patient that they're gonna use for a long time, 'cause migraine [00:08:00] is a disease that we can't cure.

[00:08:02] We only control it. So once we get you on these preventative medicines, we need to be able to use them long term. So if we're taking that stance, we need the tolerability piece of it. And effectiveness then is the sum of efficacy and tolerability. And, and it's only when we put those two together that we really get to the right decision.

[00:08:28] And then it's just shifting it early in the paradigm, right? Let's get you on an effective treatment as soon as possible to prevent you from transforming. And that's where this guideline is really useful, 'cause, like, if you do what I just said, and that, and that we have these position statements and now the guideline, and the payers start to pay attention to these guidelines, and they, they may come up with guidelines [00:09:00] themselves that match this and allow us to use these anti-CGRP drugs much earlier in the paradigm.

[00:09:10] **Billy:** So, so with, you know, effectiveness, uh, tolerability, and efficacy, um, what does a meaningful response to preventive therapy look like, um, i-in, in actual practice? And when might you continue treatment even if a patient has not achieved, like, a 50% reduction in migraine days?

[00:09:29] **Dr. Blumenfeld:** You know, this, this is interesting.

[00:09:31] You know, we see a lot of that with, um, for example, Onabot is, is, uh, highly efficacious in chronic migraine and is well-tolerated. So it hits the, uh, ef-effectiveness measure that we need for chronic migraine patients, and it, it would rise up in, based on this guideline in that population. If we're using efficacy, tolerability, it would be in line [00:10:00] with the anti-CGRP drugs like atogepant and the monoclonal antibodies.

[00:10:05] Um, so it's a very good option in that situation. But sometimes what you see happening is that it reduces intensity, but, and

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frequency maybe not as much. But patients are very happy with that because intensity interferes with their functional abilities. And so they may come back and say, "I still have frequent headache, but they really don't bother me.

[00:10:29] They're like a two out of 10." And, and that is a very important aspect of their care. Um, in-insurance companies unfortunately often focus on frequency, and they'll say, "That patient looks like a non-responder." Not true. That, that patient is a dramatic responder, um, but they're still having some days of mild headache.

[00:10:51] Um, so I think functional improvement is very important in this assessment. You can't rely just on headache [00:11:00] days or migraine days as the measure. Um, a-and we have to document that. Fortunately, we can use the MIDAS score, which is a measure of functional a-aspect of the patient's life. And, uh, a lot of times now we're seeing this where even with Medicare, the MIDAS score is recognized as a way of showing improvement.

[00:11:28] **Billy:** Um, so w-would you, would you use that and also do the gli-guideline, um, does the guideline provide, uh, recommendations and can you use the MIDAS score for, let's say, a patient who has relatively few, uh, migraine or headache days per month, but, uh, they're more severely disabling? Would, would, would this be a helpful algorithm?

[00:11:48] **Dr. Blumenfeld:** Absolutely. Yeah. I mean, the MIDAS score works great for the lower frequency headache patient, um, because if you're scoring... So, you know, it's a [00:12:00] three-month score, and it's looking at occupation, household chores, and social activities, and counting the number of days that you're impacted.

[00:12:11] Um, and if you score more than 20 across all of those domains, then you're considered to be severely disabled. So moving somebody from, let's say, 25 to less than 5 is a dramatic improvement, and you could do that with a low-frequency patient, um, using the MIDAS score very well. And you do wanna have measures like that to show that your treatment is successful, because our goal should always be to get to the highest plane possible, and we might need to add treatments or switch treatments to achieve that.

[00:12:51] You know, the one thing that's not included in this guideline is this approach to combination treatments, which is a wave [00:13:00] that is evolving now as people strive to get closer to a migraine-free state. It doesn't mean that they're gonna be free of all symptoms, but you're striving for this aspirational goal, and you often need combinations.

[00:13:15] But you would use the guideline and say, "Okay, I need to combine medicines that are well-tolerated." So I'd go to the well-tolerated box, and I'd say, "Okay, I've got my anti-CGRP. Well, okay, I need a different mechanism of action. I'm gonna add my onabot," um, and something like that in, in a, let's say, a, a chronic migraine patient where I'm trying my best to reduce the number of disabling days.

[00:13:43] **Billy:** Um, so if you had to sum up the, the guideline and all of its recommendations in, in a few points, um, what, what are the most important takeaways for a, a practicing neurologist today?

[00:13:57] **Dr. Blumenfeld:** Well, I think the important points is that the [00:14:00] guideline sh- has shown us basically the steps to take in a shared decision-making discussion.

[00:14:08] That you could use the guideline in a very proactive way in your discussion with the patient to say, "As we're picking your treatments, these are the variables that we need to think about. Efficacy, tolerability, long-term use, comorbid conditions, pregnancy. We're gonna look at all of these aspects, and we're gonna pick together the best treatment for you."

[00:14:36] So for the first time, it really sets out this approach to the discussion. Then, and, and a- again, and I, I... If, if no one comes up with a table, then I'm gonna have to develop a table. I'm gonna pull that out and practice and show the patient and say, you know, looking at the evidence across all the medicines that are available to us, you can see these [00:15:00] boxes that show us which is the, the, the most effective choice in each of the, the, the domains.

[00:15:07] And, and then use that as your guide so that you don't waste time with step edits. And then the, the biggest hope is that the payers will pay attention to this guideline, and they will shift their policies. 'Cause at the moment, I can have that discussion with the patient, and then I have to say that insurance companies may not agree with this.

[00:15:31] They may force us to use a less efficacious medicine or a less tolerated medicine, and that obviously is not gonna fit with the, the concept that's really outlined in the guideline.

[00:15:49] **Billy:** And, uh, what, what are you expecting on the horizon for preventive migraine treatment, uh, or for headache care in general?

[00:15:56] What are, what are some things you might be excited about?

[00:15:59] **Dr. Blumenfeld:** There's a [00:16:00] lot that I'm excited about. Um, migraine is, i- in terms of management, is evolving, and,

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uh, we really have a lot on the horizon that is going to develop over the next few years. In, in the immediate future, the main focus is going to be on combination treatments, because we have drugs approved but different mechanisms of action, and we're gonna combine those together.

[00:16:28] So, and, and, and we're looking for synergism there. So we're gonna focus on the mechanism of action to make sure you're not gonna necessarily use drugs that both hit the same pathway. So things like Onabut forms a foundational, uh, treatment, and then we can add anti-CGRP drugs, um, that are well-tolerated on top of that.

[00:16:53] Um, so, uh, and, and this is, you know, one of the issues with the guideline is that there is a lot of, of [00:17:00] work around this combination that has been published. But because the guideline has a cutoff of twenty twenty-four, looking at publications before that time period, it didn't capture some of the more recent work.

[00:17:15] Um, so, you know, hopefully they're not gonna wait fourteen years again, um, and there'll be some addendum to the guideline where maybe they will add this combination work. And there's a lot of work that's been done on BMI, for example. Um, Atogepant has got data that's, uh, come out showing that it has effects, uh, on BMI, and, and that doesn't get into the guideline.

[00:17:39] Um, b- but that's natural with a guideline. You have to have a cutoff date and... But then don't wait fourteen years, um, to, to revise and add. Um, so that would be my advice to the guideline committee is let's have updates, uh, that, that capture the more recent thing and, and build on what you've, you've done.[00:18:00]

[00:18:00] But as we get closer to twenty thirty, we're gonna see a lot of new drugs that I think will be approved, drugs that are looking at the PACAP, uh, pathway. So in addition to the CGRP pathway, we'll have drugs that block PACAP, which is another neuropeptide that has been shown in, in challenge studies to trigger migraines.

[00:18:24] If you give a migraine patient a PACAP infusion, it brings on the attack. And so now there are monoclonal antibodies that are being developed to target PACAP, uh, specifically the ligand. The circulating, uh, PACAP, uh, ligand is being targeted. And there are different receptors that PACAP binds to. One of these receptors is on the mast cell, and that there's a drug that's being developed that blocks that Mars cell receptor.

[00:18:54] So you get like a partial PACAP blockade, which I, I also think is very important, [00:19:00] uh, because again, we're gonna look at combination treatments in the future where we wanna block CGRP and PACAP, but we have to worry about safety when we do that. Are we gonna make it, um, unsafe because we're blocking two drugs that vasodilate?

[00:19:18] So this other product that blocks the Mars cell receptor, you get a partial PACAP, uh, blockade effect that maybe could be combined with a CGRP drug. That's very interesting. There's another one which I find absolutely fascinating, which, uh, blocks a, a channel on, um, trigeminal nerves. It's a TRPM8 channel blocker, and that channel opens up when there are changes in weather.

[00:19:49] So when the weather moves from warm to cold, this channel opens up. And for the very first time, we could understand how weather change [00:20:00] could act as a trigger for migraine by opening up this very specific channel, and this one company has now developed a product that blocks that channel. So it's gonna be very useful, particularly for weather-sensitive migraine.

[00:20:15] And this concept of weather-sensitive migraine, I think is gonna become quite a main theme in the future because now we have a treatment approach to it. You know, before patients would say, "Yeah, well, when, when there's a cloudy day, I get a headache," and, and we didn't have much power to change that. But now we will have, potentially.

[00:20:40] Um, so there's a lot that's happening that's really interesting, uh, for our migraine patients. Um, but the way that I'm thinking about all of these is I, I'm looking at the mechanisms of action and thinking about how we can combine drugs to [00:21:00] achieve this higher state, getting closer to migraine freedom, um, with each of these new additions.

[00:21:09] **Billy:** Well, thank you so much, Dr. Blumenfeld. That was, uh, that was great, and that was all my questions. So we really appreciate your time for joining us for this episode.

[00:21:17] **Dr. Blumenfeld:** Thank you for having me.

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