Highlights from Headache and EHMTIC
American Headache Society Scottsdale 2016

THOMAS N. WARD MD
PROFESSOR OF NEUROLOGY, EMERITUS
GEISEL SCHOOL OF MEDICINE AT DARTMOUTH
EDITOR-IN-CHIEF, HEADACHE: THE JOURNAL OF HEAD AND FACE PAIN
Disclosures

• I receive a stipend from the American Headache Society for services as Editor-in-Chief of Headache; the journal of head and face pain.

• I am President and Treasurer of Dartmouth Region Medical Legal Consulting.
Learning objectives

• At the conclusion of this presentation participants will be able to...
  
• 1. Discuss the various features that are available to the readers of Headache
  
• 2. Be able to access the ahead of print materials in the journal from our on-line website
  
• 3. Be aware of some of the most interesting manuscripts in Headache from the past year.
Editors of the Journal

• ROBERT E. RYAN, SR., MD Volume 1-4 1961-1965 (deceased)
• DONALD J. DALESSIO, MD Volume 5-14 1965-1975
• OTTO APPENZELLER, MD, PhD Volume 15-17 1975-1978
• LEE KUDROW, MD Volume 18-19 1978-1979
• DONALD J. DALESSIO, MD Volume 19-24 1979-1984
• JOHN G. EDMEADS, MD Volume 24-31 1984-1991
• J. KEITH CAMPBELL, MD Volume 32-41 1992-2001
• JOHN F. ROTHROCK, MD Volume 41-52 2001-2012
• THOMAS N. WARD, MD Volume 53-present 2013-
The Journal

- Can be accessed through the American Headache Society’s website.

- Current impact factor rose modestly to 2.961; we are ranked 63/192 among Clinical Neurology journals.

- “The **impact factor (IF)** of an academic journal is a measure reflecting the average number of citations to recent articles published in the journal.”

  Thomson Reuters
A few words about Headache

• Special features:
  • Our on-line version
  • Abstracts and Citations
  • Expert opinions
  • Headache toolboxes
  • Headache Rounds/Resident and Fellow section
  • Headache Currents
On-line version of the journal

• Todd Schwedt, Editor
• www.headachejournal.org
• Podcasts
• Early view
• Virtual issues
• Current issue highlights
**Virtual issues:** Virtual issues are collections of articles on a particular subject, published in *Headache: The Journal of Head and Face Pain*. They are selected by a guest editor to provide a rapid overview of the activity in a particular aspect of headache medicine. The virtual issues will be updated on a regular basis by the editor, but will not be available as a paper publication.

- The following virtual issues are available:
  - [Mild Traumatic Brain Injury, Concussion, and Post-traumatic Headache](#)
  - [Orofacial Pain, Migraine Genetics, Idiopathic Intracranial Hypertension (IIH), Neuroimaging, Migraine Research, Sleep and Headache Disorders](#)
  - [Occipital Nerve Block for Headache, Psychiatric Comorbidity and Migraine, Chronic Migraine: Transformation and Reversion Factors](#)
  - [Vestibular Migraine, Spontaneous Cerebrospinal Fluid (CSF) Leaks, Cefaliatria no Brasil | Headache Medicine in Brazil](#)
  - [Botulinum Toxin and Headache, Peripheral Nerve Blocks in Headache Treatment](#)
  - [Evidence-Based Behavioral Interventions for Treatment of Headache, Obesity and Headache](#)
  - [Medication Overuse](#)
Abstracts and Citations

- **Abstracts and Citations** Wade M. Cooper, Robert G. Kaniecki and Frederick R. Taylor
- In each issue
- Masterful survey of the headache literature with expert commentary and witty repartee
- I recommend this feature highly
Expert opinion

Randy Evans MD

Series often with a guest expert(s) discussing a timely clinical topic and often-case based.

Toolbox

- Deborah Tepper MD
- Originally conceived by Dr. John F. Rothrock
- Chronic Migraine
- Prevention of Migraine
- Onabotulinum A (Botox)
- Pregnancy and Lactation - Migraine Management
- Episodic Acute Migraine Treatment
- New Daily Persistent Headache
- Reversible Cerebral Vasoconstrictive Syndrome
- CGRP-targeted therapy for migraine
- Hemicrania continua
- Many others, designed to be copied, given to patients (can also be ordered)
Patient Education Page

- **Sex and Headache**
- **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) for Acute Migraine Treatment**
- **Opiate and Opioid (“Narcotic”) Therapy for Acute Migraine Headache**
- **Occipital Nerve Blocks**
- **Injectable Sumatriptan: Now Needle-Based or Needle-Free**
- **Menstrual Migraine**
- **Migraine Aura**
- **Headache Prevention With Complementary and Alternative Medicine**
- **Acute Migraine: Treating Early**
- **Your Visit to the Doctor: Achieving a Satisfactory Result**
- **Tool Box—Headache Web Sites**
- **Migraine "Chronification": What You Can Do**
- Compound Medications for Acute Migraine Treatment
- Patent Foramen Ovale (PFO) and Migraine
- Triptans, SSRIs/SNRIs and Serotonin Syndrome
- The Truth About Triggers
- What is Migraine?
- Topiramate (Topamax) for Migraine Prevention
- Oral Triptan Therapy
- Headache Diary
- Controlled Medication Agreement
- Monitoring Patients' Response to Acute Migraine Treatment: A Headache Attack Report Form
- Opioid Therapy for Migraine
- Patient Information Regarding Subcutaneous* Self-Administration of Dihydroergotamine
- Chronic Migraine: Medication Overuse Headache
Residents and Fellows Section

- Includes Headache Rounds, Teaching Images in Headache, Education Research, Careers in Headache Medicine, Opinions in Education Research, and Headache and the Arts.

- Drs. Morris Levin and Matthew Robbins
  Headache Rounds based on the old feature in Headache recording case rounds at the Faulkner Hospital with Dr. John Graham

- Peer-reviewed.

- Encourage medical students, residents and fellows to publish here.
Headache Currents

• Previous editors David Dodick MD, Thomas Ward MD

• Current editor Stewart Tepper MD now at Dartmouth!!!

• From the July/August 2016 issue: Coeytaux RR, Befus D. Role of Acupuncture in the Treatment or Prevention of Migraine, Tension-type Headache, or Chronic Headache Disorders.

New feature

• Associate provider column

• Monthly feature provided by Lynda Krasenbaum APRN

• Content will evolve over time based on input from nurse practitioners, physician assistants.

• Highlight content of interest to associate providers.
Wolff Award 2016

• I should note that this year there was no Wolff Award given. To quote directly from the journal’s website “The Harold G. Wolff Award is granted annually by the American Headache Society for the best paper on headache, head or face pain and the nature of pain itself. The recipient is invited to present the paper at the Society’s annual meeting, which is then subsequently published in Headache. For more information on the Wolff Award please visit www.AmericanHeadacheSociety.org.”

• There is a $10,000 award given as well.
Member’s Choice Award

• This award is chosen from a list of 5 articles which I select (and those 5 cannot include the Wolff Award nor articles which I have commissioned). The members are then allowed to vote which results in the selection of their favorite article.

Some highlights from the past year

- Pediatric collection:


Jason Roberts PhD  Executive Editor, Headache


and


- Conclusions
  - Asthma is associated with an increased risk of new onset CM 1 year later among individuals with EM, with the highest risk being among those with the greatest number of respiratory symptoms. The exact mechanisms underlying this association are unknown, but could suggest mast cell degranulation, autonomic dysfunction, or shared genetic or environmental factors.

• Abstract

• The development of vagus nerve stimulation (VNS) began in the 19th century. Although it did not work well initially, it introduced the idea that led to many VNS-related animal studies for seizure control. In the 1990s, with the success of several early clinical trials, VNS was approved for the treatment of refractory epilepsy, and later for the refractory depression. To date, several novel electrical stimulating devices are being developed. New invasive devices are designed to automate the seizure control and for use in heart failure. Non-invasive transcutaneous devices, which stimulate auricular VN or carotid VN, are also undergoing clinical trials for treatment of epilepsy, pain, headache, and others. Noninvasive VNS (nVNS) exhibits greater safety profiles and seems similarly effective to their invasive counterpart. In this review, we discuss the history and development of VNS, as well as recent progress in invasive and nVNS.
• Tepper SJ. Editorial-Indomethacin. Headache 2016; 56(2): 421. (Headache Currents)


Migraine is comorbid with obesity. Recent research suggests an association between migraine and adipocytokines, proteins that are predominantly secreted from adipose tissue and which participate in energy homeostasis and inflammatory processes.

Conclusions

While the existing data are suggestive that adipokines may be associated with migraine, substantial study design differences and conflicting results limit definitive conclusions. Future research utilizing carefully considered designs and methodology is warranted. In particular careful and systematic characterization of pain states at the time of samples, as well as systematic consideration of demographic (eg, age, sex) and other vital covariates (eg, obesity status, lipids) are needed to determine if adipokines play a role in migraine pathophysiology and if any adipokine represents a viable, novel migraine biomarker, or drug target.


- Recommendations

- Intravenous metoclopramide and prochlorperazine, and subcutaneous sumatriptan should be offered to eligible adults who present to an ED with acute migraine (Should offer—Level B). Dexamethasone should be offered to these patients to prevent recurrence of headache (Should offer—Level B). Because of lack of evidence demonstrating efficacy and concern about sub-acute or long-term sequelae, injectable morphine and hydromorphone are best avoided as first-line therapy (May avoid—Level C).
Silberstein SD. The American Headache Society Cluster Guidelines. Headache 2016; 6(7); 1091-1092


- Results and Recommendations

- For acute treatment, sumatriptan subcutaneous, zolmitriptan nasal spray, and high flow oxygen remain the treatments with a Level A recommendation. Since the 2010 review, a study of sphenopalatine ganglion stimulation was added to the current guideline and has been administered a Level B recommendation for acute treatment. For prophylactic therapy, previously there were no treatments that were administered a Level A recommendation. For the current guidelines, suboccipital steroid injections have emerged as the only treatment to receive a Level A recommendation with the addition of a second Class I study. Other newly evaluated treatments since the 2010 guidelines have been given a Level B recommendation (negative study: deep brain stimulation), a Level C recommendation (positive study: warfarin; negative studies: cimetidine/chlorpheniramine, candesartan), or a Level U recommendation (frovatriptan).

- Conclusions

- This AHS guideline can be utilized for understanding which therapies have superiority to placebo or sham treatment in the management of CH. In clinical practice, these recommendations should be considered in concert with other variables including safety, side effects, patient preferences, clinician experience, cost, and the invasiveness of the intervention. Given the lack of Class I evidence and Level A recommendations, particularly for a number of commonly used preventive therapies, further studies are warranted to demonstrate safety and efficacy for established and emerging therapies.
New (revived) feature: book reviews

• Very occasional.
• Professor Allan Purdy, President of the American Headache Society
• The Heart’s Hard Turning: The Affairs of Men
• John Farr Rothrock
Lasmiditan, a selective 5-HT1F agonist without vasoconstrictive action. The Samurai Phase 3 pivotal trial comparing lasmiditan 100mg, 200mg and placebo single dose for a migraine attack (second dose permitted for rescue) looking a 2 hour pain free and 2 hour most bothersome associated symptom-free at 2 hours. 2,232 patients randomized. >80% of enrolled subjects have multiple CV risk factors.

<table>
<thead>
<tr>
<th>HEADACHE PAIN RELIEF (ITT)</th>
<th>Lasmiditan 100mg</th>
<th>Lasmiditan 200mg</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients migraine headache pain relief at two hours</td>
<td>59.4%</td>
<td>59.5%</td>
<td>42.2%</td>
</tr>
<tr>
<td>Odds Ratio (95% confidence interval)</td>
<td>2.4 (1.8 – 3.1)</td>
<td>2.5 (1.9 – 3.3)</td>
<td></td>
</tr>
<tr>
<td>p-value</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td></td>
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</table>
• KEY SECONDARY ENDPOINT  

<table>
<thead>
<tr>
<th>Treatment</th>
<th>% of patients MBS free at two hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lasmiditan 100mg</td>
<td>40.9%</td>
</tr>
<tr>
<td>Lasmiditan 200mg</td>
<td>40.7%</td>
</tr>
<tr>
<td>Placebo</td>
<td>29.5%</td>
</tr>
</tbody>
</table>

• p-value  

<table>
<thead>
<tr>
<th>Treatment</th>
<th>p-value</th>
</tr>
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<tbody>
<tr>
<td>Lasmiditan 100mg</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Lasmiditan 200mg</td>
<td>p &lt; 0.001</td>
</tr>
</tbody>
</table>
## TEAE

- Mostly CNS-related
  - lasmiditan 100mg: 11.9%
  - lasmiditan 200mg: 15.4%
  - placebo: 3.1%

- Dizziness
  - lasmiditan 100mg: 11.9%
  - lasmiditan 200mg: 15.4%
  - placebo: 3.1%

- Paresthesia
  - lasmiditan 100mg: 5.7%
  - lasmiditan 200mg: 7.6%
  - placebo: 2.1%

- Somnolence
  - lasmiditan 100mg: 5.2%
  - lasmiditan 200mg: 5.3%
  - placebo: 2.3%

- Fatigue
  - lasmiditan 100mg: 3.8%
  - lasmiditan 200mg: 3%
  - placebo: 0.2%

- Vertigo
  - lasmiditan 100mg: 1%
  - lasmiditan 200mg: 0.3%
  - placebo: 0

- No serious adverse cv events
In summary

• Being the editor is a great job. You see many things.

• The good, the bad and the ugly.

• It is our journal, we depend on quality submissions especially from our membership.

• Please send us your best work, your colleagues will see it!

• Please submit your best work for the Wolff Award.

• Fellowship directors, please encourage your trainees to get published (the Resident and Fellows Section is a great venue in which to accomplish that).

• Please send me your encouragement, criticisms, and suggestions.
Thank you very much.

- wardt1978@gmail.com

The view from Lake Ward