CANADIAN HEADACHE CONFERENCE
COAST TO COAST

A Case of Chronic Migraine

Elizabeth Leroux, MD, FRCPC

Disclosures: Elizabeth Leroux, MD, FRCPC

Board member, consultant and/or speaker:

- Allergan/AbbVie
- Eli Lilly
- Lin Pharmaceuticals
- Lundbeck
- Novartis
- Nuvo-pharm
- Paladin Pharma
- Pfizer
- Teva neuroscience

Disclosure of Off-Label and/or Investigative Uses: SOME.

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Learning Objectives

Upon completion of this activity, learners will be able to

- Detail the mangement of chronic migraine over time and the relevance of combination therapy
- Emphasize the importance of a headache diary
- Underline the relevance of life events and comorbidities on the clinical management of chronic migraine

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Case, Female, 54 Years Old

Prior Medical History:

- Mild IBS
- Dyslipidemia, treated, no other vascular issues
- Sleep Apnea 2022 CPAP machine ** no change in migraine
- Car accident 2012 (43 yo)

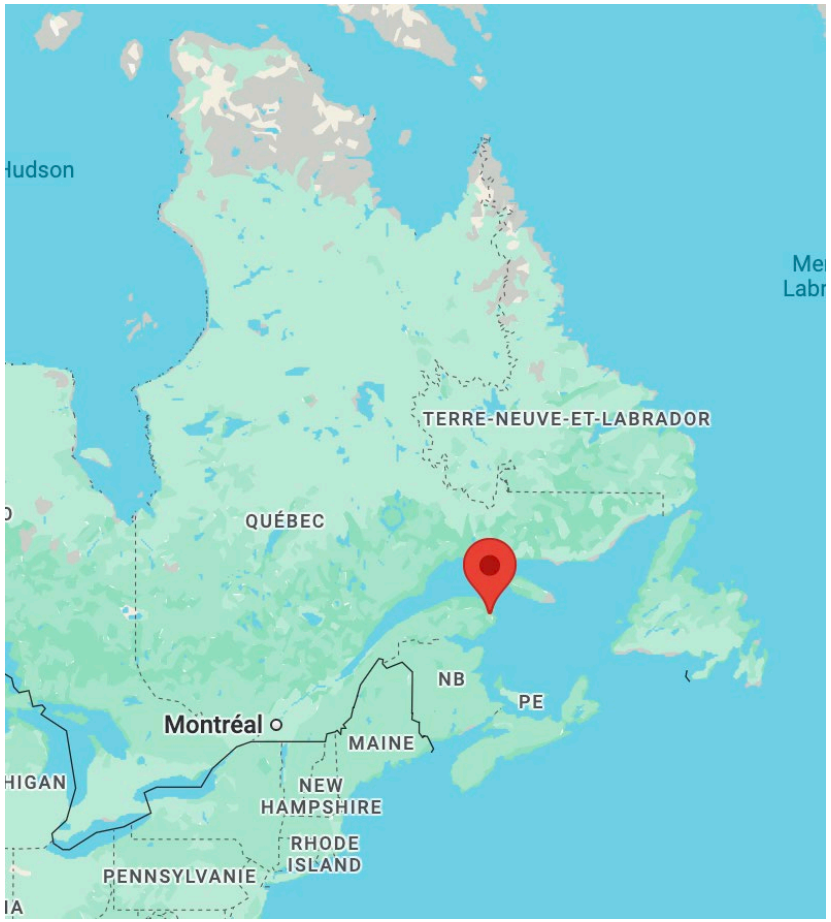
No:

- Mental health issues
- Childhood trauma

Employment:

- Physiotherapist on Medical Leave since Sept 2021

Private insurance
Has seen 2 neurologists



Driving Time 26h

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First Intake

- No migraine as kid or teen
- G1 18 G2 31
- Migraine started in mid-thirties
- Splitting HA, then unilateral on the RIGHT
- Menstrually related
- Duration 1 day with NSAIDs
- 37 HAT but ovaries in place
- 40ies: progressive deterioration
- 43 2012 car accident
- 48 or so: had HAFD but not many
- Increase in triptans but no overuse until 2020

CURRENT: SINCE 2021

BASELINE:

- No Headache free days
- Constant tinnitus, always light sensitive
- Neck pain: 3-4/7

ATTACK:

- Different locations, quick or progressive
- Often wakes up with attack
- Sonophobia +++ Photophobia ++ Osmo –
- Nausea ++ Vomiting 1/month
- Neck +++ Jaw no Sinus with the HA

AURA: None

Triggers: shoulders/neck (doing hair), cleaning, lifting Tx with ELE, with overuse (16-20/month)

ED Visit: Yes, 2021, 2023

Mood is impacted. Sleep is poor

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Previous Trials and Current Medications

BEHAVIOURAL TRIALS

- Osteopath
- Chiropractor
- Massage
- Dr Ho
- Cut her hair
- Quit smoking
- Tried exercises, walking
- Relaxation

Many thousand dollars

PREVENTIVE TRIALS

- Amitriptyline 2012-2015 25 mg deteriorated HA ?
- Tizanidine 2015 no benefit
- Pregabalin 75 mg 2015 worse, somnolent
- Nadolol 2015 40 mg hypotension
- Duloxetine 30 mg dizziness
- Propranolol 2018 40 mg hypotension
- Gabapentin 2019 dose? Not effective
- Topiramate 50 mg 2021 paresthesias, face numbness, cognitive AEs
- Erenumab sept 2021 70 mg then 140 mg no benefit, but tolerated

CURRENT MEDICATIONS

- NO or ACTM IBU
- Eletriptan 40 mg 4/7:
  - 16-20/30
- Erenumab 140 mg
- Cyclobenzaprine PRN
- Sertraline 75 mg
- Pravastatin 40 mg

IMAGING

MRI C-C+ 2018, 2020, 2021, 2023 no MS, few hyperT2s.
CT Feb 2025 done for change in HA worse with Valsalva, normal.

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A VERY Classic Situation

- Chronic migraine without aura with overuse
- Post-traumatic headache/history of trauma
- Cervicogenic aspects
- Secondary mood disorder and insomnia.
- Sleep apnea, treated

avril 2023	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	T
Céphalée 0 1 2 3	1	2	3	3	3	3	3	1	2	2	1	1	2	2	1	3	3	2	3	3	1	2	2	2	3	3	2	1	3	2	
Aura																															0
Acétaminophène								✓					✓	✓	✓						✓							✓			6
Naproxène								✓						✓	✓						✓							✓			5
Almotriptan	✓		✓	✓	✓	✓		✓					✓	✓	✓						✓							✓			11

The Work Begins

EVOL November 2022

Post FIRST TOXIN NO RESPONSE 30/30

- Wakes up with migraine.
- If not, activities will bring one.
- ELE 20/30, she tries to limit
- ** Candidate acute gepants

EVOL March 2023 post 2d TOXIN

- Maybe a response in intensity
- Ubrogepant no benefit
- Had 2 headache free days!
- Try odansetron or prochloperazine IR
- Encouragement

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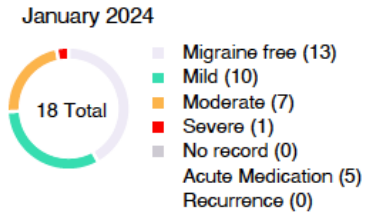
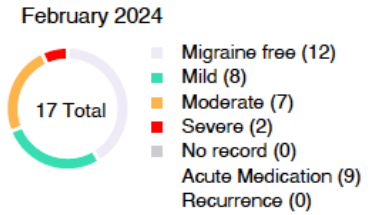
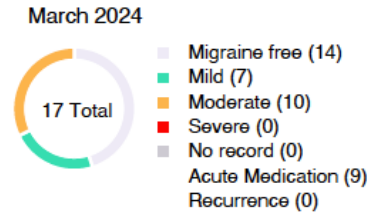
In Progress

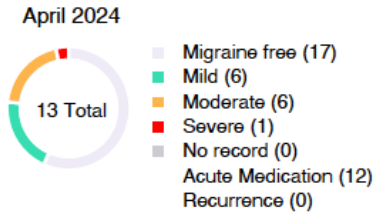
EVOL June 2023 BETTER 3d TOXIN

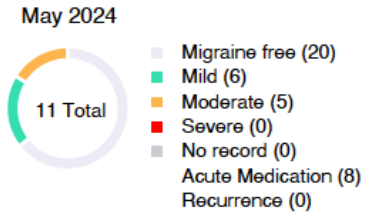
- Discussion on triggers
- Attacks less intense
- 6 headache-free days
- Uses ELETRIPTAN 10-12/month
- Still sensitive to valsalva, and movement
- Gluten FREE 100%, better energy, less bloating
- Adding a CGRP MAB is next step

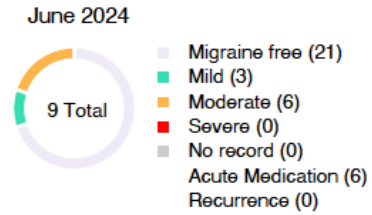


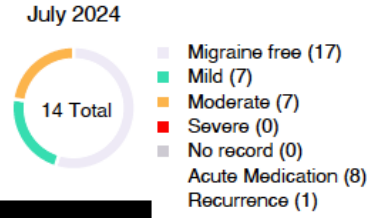


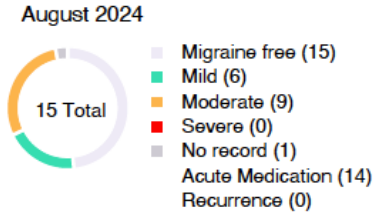


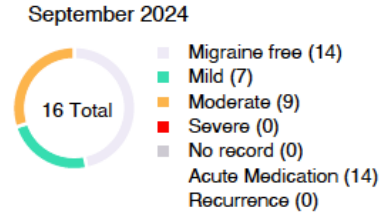












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Aura					✓					✓	✓			✓	✓																	5
Menstruation																																0
Eletriptan		✓			✓	✓				✓		✓			✓					✓			✓								✓	9
Naproxen			✓								✓		✓								✓			✓						✓		6

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The Story Goes On

EVOL March 2025
- Allergy says OK for EPZ
- Lost her father January
- Had the flu
- 13-16 instead of 11
- Would have been worse without the toxin

EVOL June 2025 BETTER
- Nothing major going on
- FIRST EPZ IV April 26th,
- Well tolerated
- PRE EPZ 14/30
- Result in May 9/30

EVOL Sept 2025 MUCH BETTER 5/30
- Tonsillectomy for sleep apnea
- July difficult 12/30
- Will have PSG to check need for CPAP
- Started Thyroid treatment in August
- TSH baseline very midly elevated

- August 5/30
- It's like a MIRACLE
- Partner hardly believes it
- Planning RTW

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A Story of Success

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Aura					✓					✓	✓			✓	✓																	5
Menstruation																																0
Eletriptan		✓			✓	✓				✓		✓			✓					✓			✓							✓	9
Naproxen			✓								✓		✓								✓			✓					✓		6

August 2025	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	T
Headache 0 1 2 3	0	0	0	0	0	1	0	0	0	0	1	2	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	
Aura																			✓													1
Menstruation																																0
Eletriptan												✓							✓	✓												3
Naproxen																																0

Making migraine visible:
The Canadian Migraine Tracker

Canadian Migraine Tracker

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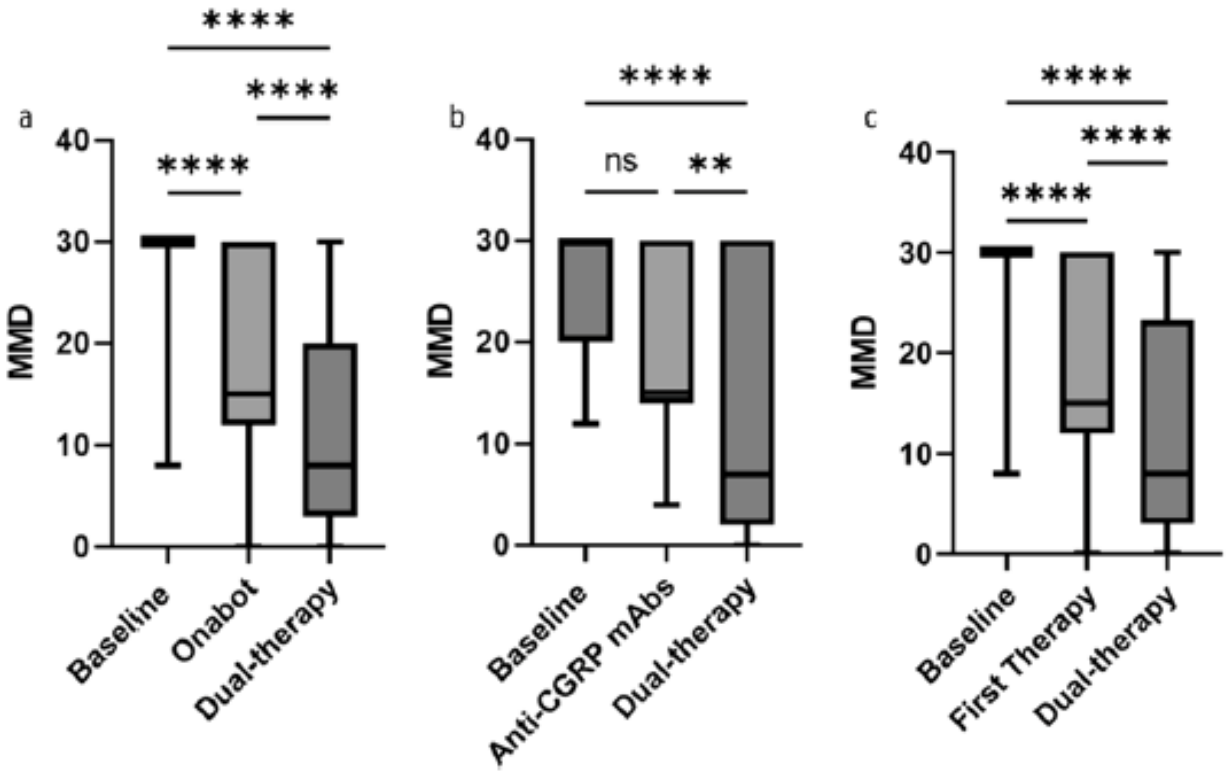
CGRP Blockade + Toxin Combination:
The Evidence is Piling up (and the insurers should consider it)

- 229 consecutive therapy: had BOTH BTX (3 cycles) and a CGRP MAB (3 months) with NO overlap (at least 3 months between therapies)
- 194 dual therapy patients (at least 3 months of concurrent therapy)
  - 171 BTX first: MMD decrease from 30 to 19 days, then down to 12
  - 23 MAB first: MMD decrease from 20-30 to 15, then 15 to 7
  - 80% > 6 months

	50%	75%
BTX only	49%	16%
MAB only	45%	19%
Dual therapy	68%	46%

Salim A, Hennessy E, Sonneborn C, Hogue O, Biswas S, Mays M, et al. Synergism of Anti-CGRP Monoclonal Antibodies and OnabotulinumtoxinA in the Treatment of Chronic Migraine: A Real-World Retrospective Chart Review. CNS Drugs. 2024;38(6):481-91.

CGRP Blockade + Toxin Combination:
Results from the Cleveland Clinic Cohort (Dual=194, Consecutive=229)



BTX then MAB **MAB then BTX** **ALL dual pts**

Patients with Dual Therapy

In my practice:
A majority of refractory chronic migraine patients

Letter for insurance from the Canadian Headache Society available.

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A Supporting Letter from CHS is Available

Position Statements

The Canadian Headache Society (CHS) provides official guidance to support clinicians in delivering evidence-based, ethical, and comprehensive migraine care. The following advocacy resources outline CHS's position on key issues in access, coverage, and treatment standards.

Not Just Needles: Providing Ethical and Comprehensive Migraine Care
Summary: This statement emphasizes that migraine care must be holistic, not reduced to procedures alone. It calls on providers to deliver comprehensive, ethical care that includes diagnosis, education, lifestyle strategies, and preventive therapies.

Download Here

Prioritizing Access to Evidence-Based Migraine Preventive Treatments
Summary: CHS urges policymakers and payers to modernize reimbursement policies to reflect current evidence. CGRP monoclonal antibodies and gepants should be considered first-line preventive treatments, improving outcomes and reducing the burden of migraine.

Releasing September 16th

Combination Use of OnabotulinumtoxinA (Botox) and CGRP-Antagonist (CGRPa) Agents for Migraine
Summary: This position highlights the clinical and economic rationale for combination therapy in chronic migraine. CHS stresses the importance of access, noting strong evidence for improved patient outcomes when these treatments are used together.

Releasing September 24th

Summaries and Literary Reviews

MAB and BTX Combination Insurance Letter
Summary: CHS addresses recent insurance practices denying concurrent coverage of onabotulinumtoxinA (Botox) and CGRP monoclonal antibodies. This letter details the scientific rationale, clinical experience, and cost-effectiveness supporting combined use in refractory chronic migraine.

Download Here

Arguments and references

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Key Points From This Story

- Chronic disease management model, step by step
  - Treatments may take 6-9 months to work
  - Admin and medical barriers to manage
- Patients may not respond to a CGRP MAB and then respond to another
- Frequency is not the only parameter to consider
  - Intensity, function, acute med use, response to acute meds, sleep, mood
- Stressors must be considered when evaluating response
- Management of comorbidities is sometimes key
- Do not give up if patient cannot be stabilized with one preventive
- The combination of toxin therapy and CGRP blockade for CM is promising

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THANK YOU