

## Migraine Often Improves Over Long Term

BY MICHELE G. SULLIVAN  
Mid-Atlantic Bureau

CHICAGO — Migraine appears to have a favorable long-term prognosis in many patients, with more than a third experiencing cessation of headache and the vast majority of persistent migraineurs reporting symptom improvement over 12 years.

“These data probably reflect the natural course of migraine disease,” Dr. Carl Dahlöf said at the annual meeting of the American Headache Society. “They also probably suggest that we are doing a better job with the newer drugs, and appear to be preventing episodic migraineurs from developing chronic migraine.”

Dr. Dahlöf of the Göteborg (Sweden) Migraine Clinic presented 12 years of follow-up data obtained on 374 patients diagnosed with migraine before 1996. The group included 200 men and 174 women, a ratio that does not reflect the gender balance seen in any headache practice, Dr. Dahlöf noted. “We chose equal numbers of men and women because we wanted to see if there were any gender differences in progression or improvement over the years.”

All patients participated in a telephone survey that assessed the changing pattern of their migraine from 1994 to 2006.

Over the follow-up period, 29% of patients (57 women and 53 men) reported that their migraines had ceased. For women, migraine without aura, the absence of hereditary factors, and the absence of aggravation from physical activity appeared to predict cessation. For men, the apparent predictors were a nonthrobbing migraine, and the absence of nausea and sensitivity to smells.

“Surprisingly, we also found in men that smoking and lack of alcohol as a trigger factor were also predictors,” Dr. Dahlöf said. “We had expected that more frequent or severe migraine would predict progression, but we did not find this as true.”

The remaining 264 patients continued to experience migraine, but the majority reported at least some improvement of their symptoms over time.

In all, 80% reported a change in headache frequency, with 80% of these saying they had fewer attacks per month.

More than half of persistent migraineurs reported a change in duration of headache, with 66% saying their attacks had grown shorter. In terms of severity, 66% of migraineurs reported a change in pain intensity over time, with most of this group (84%) reporting milder pain.

Of the entire group of 374 patients, only six (1.6%) developed chronic migraine, a number that is vastly smaller than the annual transformation rate reported in many studies, Dr. Dahlöf said.

Despite the changing pattern of migraine, a significant proportion of migraineurs continued to experience impairment in their quality of life, including decreased family and social functioning, and absence from work. ■

## Few Migraineurs Use Emergency Department

BY ALICIA AULT  
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CHICAGO — Headache is the fifth most common emergency department complaint, but only a small percentage of migraineurs use emergency care for treatment, according to an analysis of the American Migraine Prevalence and Prevention study presented at the annual meeting of the American Headache Society.


Dr. Benjamin Friedman of the Albert

Einstein College of Medicine, New York, said he and his colleagues sought to determine how often Americans with headache use the ED or an urgent care facility, and what the risk factors were for frequent use.

The goal of the study was to discern ways to prevent urgent headache visits. Currently there are about 5 million visits a year for headache, he said.

The American Migraine Prevalence and Prevention study (AMPP) is an ongoing multisite survey that began in 2004

when a self-administered headache questionnaire was mailed to a random sample of 120,000 households. The study was supported by a grant to the National Headache Foundation from Ortho-McNeil Inc. Of the 162,576 individuals who responded, 30,721 self-reported severe headaches. Dr. Friedman and his colleagues mailed a follow-up survey in 2005 to a random subsample of 24,000 of the headache sufferers, asking for data on emergency or urgent care use within the previous 12 months.



# NEW SEROQUEL XR

## once-daily for schizophrenia

In patients with schizophrenia

- SEROQUEL XR has proven efficacy and broad symptom improvement<sup>1</sup>
- During titration in the first week, SEROQUEL XR was generally well tolerated<sup>\*2</sup>

### Important Safety Information

- SEROQUEL XR is indicated for the treatment of schizophrenia. Patients should be periodically reassessed to determine the need for treatment beyond the acute response
- **Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk (1.6 to 1.7 times) of death, compared to placebo (4.5% vs 2.6%, respectively). SEROQUEL XR is not approved for the treatment of patients with dementia-related psychosis (see Boxed Warning)**
- Hyperglycemia, in some cases extreme and associated with ketoacidosis, hyperosmolar coma, or death, has been reported in patients treated with atypical antipsychotics, including quetiapine. The relationship of atypical use and glucose abnormalities is complicated by the possibility of increased risk of diabetes in the schizophrenic population and the increasing incidence of diabetes in the general population. However, epidemiological studies suggest an increased risk of treatment-emergent, hyperglycemia-related adverse events in patients treated with atypical antipsychotics. Patients starting treatment with atypical antipsychotics who have or are at risk for diabetes should undergo fasting blood glucose testing at the beginning of and periodically during treatment. Patients who develop symptoms of hyperglycemia should also undergo fasting blood glucose testing
- A potentially fatal symptom complex, sometimes referred to as Neuroleptic Malignant Syndrome (NMS), has been reported in association with administration of antipsychotic drugs, including quetiapine. Rare cases of NMS have been reported with quetiapine. Clinical manifestations of NMS are hyperpyrexia, muscle rigidity, altered mental status, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis), and acute renal failure. The management of NMS should include immediate discontinuation of antipsychotic drugs

\*Data combined from 2 multicenter, 6-week, randomized, double-blind, placebo-controlled schizophrenia trials comparing SEROQUEL XR (n=679) to placebo (n=235). During Week 1, incidence of somnolence was 9.0% vs 1.3% for placebo, sedation was 7.4% vs 3.4% for placebo, dizziness was 5.9% vs 2.6% for placebo, dry mouth was 6.8% vs 0.9% for placebo, headache was 3.4% vs 6.4% for placebo, and insomnia was 2.8% vs 7.2% for placebo.<sup>2</sup>

**Please see Brief Summary of Prescribing Information, including Boxed Warning, on adjacent pages.**

Data were collected on 13,451 respondents. Among those categorized with migraine or probable migraine, 94% did not visit the emergency department at all, leaving 859 patients who did report a visit. Among those, 48% (412) reported only one visit within the past year. About a third (274) reported 2-3 visits, only 14% (120) reported up to nine visits, and 53 patients reported more than nine visits.

The frequent users, which he classified as 20% of the 859 ED visitors, accounted for 51% of all visits.

The most-cited reasons for going to the ED or urgent care facility included unbearable pain, the inability to reach a pri-

mary physician, the ability to get better or different medications, and concern about the significance of the pain (for instance, whether it might be the result of meningitis). A small number of patients said the ED was the primary source of care, and an equal number cited insurance or other financial barriers to care as the reason why they went to an urgent facility instead of a primary physician.

Using a multivariate analysis, Dr. Fried-

man and his colleagues determined that the main risk factors for urgent care use were the use of those facilities for non-headache care and a severe migraine disability assessment scale (MIDAS) score. Having insurance was protective against ED visits, he said. The risk factors were similar in frequent ED users, with stronger associations.

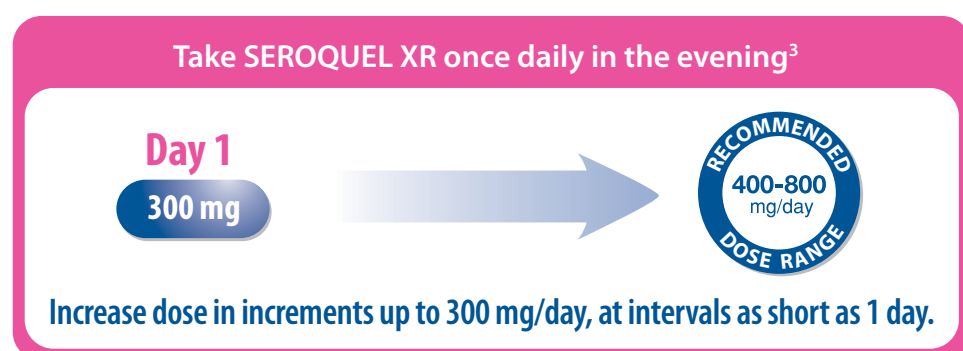
The investigators concluded that urgent care facilities are used infrequently for the

management of severe headache on a population level, but—because the disorder is so prevalent—headache is a common complaint in the ED. Frequent users are uncommon, but they account for the majority of visits to ED and urgent care. In terms of modifiable risk factors, ED use is associated with more severe headache, so treating the underlying headache may help prevent urgent care visits, Dr. Friedman said.

Dr. Friedman noted that the study is limited by its reliance on self-reporting of ED visits and because it is cross-sectional. Dr. Friedman reported no disclosures other than the study funding. ■

**Among those categorized with migraine or probable migraine, 94% did not visit the ED and 859 patients did report a visit.**

*FDA-approved starting dose of SEROQUEL XR is 300 mg on Day 1... get your patients with schizophrenia to a recommended dose as early as Day 2<sup>3</sup>*



- To be taken without food or with a light meal (approximately 300 calories)
- Dosage adjustments may be necessary, based on individual response and tolerability
- SEROQUEL XR tablets should be swallowed whole and not split, chewed, or crushed
- In the elderly and patients with hepatic impairment, consideration should be given to a lower starting dose, a slower rate of dose titration, careful monitoring during the initial dosing period, and a lower target dose. For patients who require less than 200 mg/dose, use the immediate-release formulation (see Prescribing Information)

#### Important Safety Information (continued)

- Tardive dyskinesia (TD), a potentially irreversible syndrome of involuntary dyskinetic movements, may develop in patients treated with antipsychotic drugs. The risk of developing TD and the likelihood that it will become irreversible are believed to increase as the duration of treatment and total cumulative dose of antipsychotic drugs administered to the patient increase. TD may remit, partially or completely, if antipsychotic treatment is withdrawn. Quetiapine should be prescribed in a manner that is most likely to minimize the occurrence of TD
- Warnings and Precautions also include the risk of orthostatic hypotension, cataracts, seizures, hyperlipidemia, and possibility of suicide attempts. Examination of the lens by methods adequate to detect cataract formation, such as slit lamp exam or other appropriately sensitive methods, is recommended at initiation of treatment or shortly thereafter, and at 6-month intervals during chronic treatment. The possibility of a suicide attempt is inherent in schizophrenia, and close supervision of high-risk patients should accompany drug therapy
- The most commonly observed adverse events associated with the use of SEROQUEL XR versus placebo in clinical trials for schizophrenia were dry mouth (12% vs 1%), constipation (6% vs 5%), dyspepsia (5% vs 2%), sedation (13% vs 7%), somnolence (12% vs 4%), dizziness (10% vs 4%), and orthostatic hypotension (7% vs 5%)
- In long-term clinical trials of quetiapine, hyperglycemia (fasting glucose  $\geq 126$  mg/dL) was observed in 10.7% of patients receiving quetiapine (mean exposure, 213 days) vs 4.6% in patients receiving placebo (mean exposure, 152 days)

**References:** 1. Kahn RS, Schulz C, Palazov VD, et al. Efficacy and tolerability of once-daily extended release quetiapine fumarate in acute schizophrenia: a randomized, double-blind, placebo-controlled study. *J Clin Psychiatry*. 2007;68:832-842. 2. Data on file, DA-SXR-05, AstraZeneca Pharmaceuticals LP. 3. SEROQUEL XR Prescribing Information.

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