INTERVIEW TRANSCRIPT

DISCUSSIONS WITH WORLD-LEADING EXPERTS

The Six Most Common Mistakes in Migraine Management

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Introduction (00:05): For many people with migraine, finding relief can take years of trial and error and persistence. Even the most experienced patients can fall into patterns that can make it harder to control, not from failure, but because this is such a complex condition. To help us recognize these common traps and take practical steps toward better control, we're joined by Dr. Deborah Friedman, a neurologist specializing in headache medicine and neuro-ophthalmology.

Introduction (cont.) (00:28): Today, she'll share what decades of clinical and research experience have told her about the most common pitfalls in migraine management, and most importantly, what we can do differently to gain better control. Dr. Friedman, welcome back to the Migraine World Summit.

Deborah Friedman (00:43): Carl, it is always great to be here.

Carl Cincinnato (00:46): You've treated thousands of people with migraine. What are some of the most common barriers that keep people [from] getting better control?

Dr. Friedman (00:52): When we talk about acute treatment, I would say the No. 1 barrier is not taking their medication early enough. We've been talking about this for decades, and I'm not sure why it is. Maybe people just think this isn't going to be "the bad one," but we know that early treatment makes a huge difference. I think that still some people are reluctant to use preventive treatment, even though we have a lot of great preventive treatments out there. I would say those are my top two.

Carl Cincinnato (01:25): Let's go into these common barriers or mistakes that are being made. I want to just state that this isn't placing blame on anyone. It's really to help us unlock better results for our own health and well-being. You mentioned that not getting adequate relief from an acute treatment was one of the key barriers there. As we talk about acute treatments, can we first go over the categories of acute treatment and options within each of those categories — just the main ones?

Dr. Friedman (01:55): Sure. I know they're different in every country. There are simple analgesics like acetaminophen, paracetamol, nonsteroidal anti-inflammatories [NSAIDs], combination analgesics like acetaminophen and caffeine, and medications like that. On the prescription side, we have triptans, which we've had since the early 1990s. Now we have the CGRP [calcitonin gene-related peptide] antagonists, which have been a huge boon. We have neuromodulation devices, homeopathic things, right? Like ice, heat, rest.

Dr. Friedman (02:43): Then there are medications that we try not to use, such as opioids, for example, [or] butalbital. Some countries, they still use a lot of ergotamine tartrate. I would say in the United States, that's not very common. There really are a lot of choices.

Carl Cincinnato (03:02): What are the biggest errors you see, things like waiting too long to treat or using the wrong medication?

Dr. Friedman (03:08): Sure. I think it's really hard to find a balance with all of this, especially people that have frequent migraine. They may be treating kind of preemptively sometimes or using their acute medicine like we would use a preventive medication because they have something to do that day and they can't afford to have a migraine, and so they're just going to take the medicine. Unfortunately, that can, in the long run, lead to overuse of acute medicine. Sometimes that can make the migraines worse over time.

Dr. Friedman (03:42): I think, again, the other problem is not taking acute medicine appropriately early enough. We know from research that was done a long time ago from Dr. Rami Burstein at Harvard that taking triptans early really made a huge difference because there are changes that occur in the brain after about an hour or so of the migraine process that make it harder and harder to treat.

Dr. Friedman (04:08): It's sort of a delicate art, almost, of finding the right treatment that's going to work consistently, and also taking it at the right time, but not overusing it. It's not simple, and I totally understand that, but I think there is room for improvement.

Carl Cincinnato (04:28): What tips do you give [to] some of your patients to do exactly that, to optimize their acute plan and take the medication early without risking medication overuse headache?

Dr. Friedman (04:37): I think it's important for people that are seeing patients to ask them specifically how well their acute medications are working. There are questionnaires we could use for this, but it's just a simple question, right? Are you getting good relief? Does it work at least more often than not? Hopefully it works every time. Do you have side effects, and are you happy with it? I think that covers most of the bases.

Dr. Friedman (05:02): If the patient is saying no — maybe they're not taking their acute treatment because it makes them sleepy and they can't function, or maybe they get nauseated from it — then that's an issue, and we need to look at changing the acute treatment.

Dr. Friedman (05:15): And then for people that tell me that they wait to take their medicine, I usually — you know me, I'm kind of direct to the point — I usually just ask them, "Well, how often do you get this feeling, whatever it is, that starts their migraine and it doesn't turn into a migraine?" And they usually say, "Well, it always turns into a migraine." So the take-home lesson from that is: Take your medicine as soon as you get that feeling.

Carl Cincinnato (05:42): You mentioned nausea that people can experience from medication as a reason why they might not use the medication. We also get nausea from migraine, and if we have nausea, does that block the absorption of an oral tablet if we're taking an oral treatment for our acute attack?

Dr. Friedman (05:58): Sure, and that's a huge issue. So not only nausea and vomiting, but even for people that don't get nauseated, most people with migraine have what we call gastric stasis during an attack. So their stomach kind of stops moving, it stops pushing food and everything the way it's supposed to go in your gastrointestinal tract, and it does limit the absorption of oral medications.

Dr. Friedman (06:23): I think another thing that we should be talking about that we're not talking about is the weight loss medications, the GLP-1s. One of the reasons that they work is that they make people feel full, and they feel full because their stomach is not pushing things through like they should.

Dr. Friedman (06:41): So I don't really know if anybody has really looked at this scientifically, but it makes me wonder whether people who are taking those medications need to step back and analyze for themselves whether or not they think they're working as well as they used to, and maybe we should think about non-orals in some of those people.

Carl Cincinnato (07:03): If your patients aren't getting moderate [relief] or back to function within two hours, are you still having the conversation with them about, "OK, well, let's look at what else we can do to your acute treatment regimen?" Or if the migraine comes back within 24 hours, are those signals to you that we need to keep working on these?

Dr. Friedman (07:22): Yes, definitely. I'll be honest and say I don't always talk about two hours. I usually ask the patient, "How long does it take before you can get back to doing whatever you wanted to do?" which may not be complete relief. But I don't necessarily throw out the two hours, even though it's the FDA standard of how we do our clinical trials. But when people are having to redose, I think that's definitely an issue because they have recurrence.

Carl Cincinnato (07:49): Many people try preventives, but they give up quickly, or they think that they should be chronic before they even need to consider prevention. What are some of the most common pitfalls with prevention and ways around them that you see?

Dr. Friedman (08:01): The American Headache Society has guidelines for when we should think about prevention. And they say that anybody who has at least four migraine days a month should be considered for prevention. But even if there are fewer than four migraine days a month, but the headaches are disabling, then those people are candidates for prevention. And frankly, if the patient wants prevention, they're candidates for prevention.

Dr. Friedman (08:28): My personal opinion is that we kind of trivialize what we call episodic migraine, meaning less than half the days per month. I just — I can't imagine what it would be like to have migraine seven days out of the month, right? That's not trivial. Even one day out of the month, if it's bad and you're missing work, is not trivial.

Dr. Friedman (08:49): So I tend to encourage people to think about prevention, even when they have relatively low-frequency, as it's termed, migraine attacks during the month. So I think that's one barrier, that people think, "Well, it's just not bad enough." I don't know. I think almost any migraine is "bad enough" to start thinking about prevention. And again, it's a balance, right? The treatment shouldn't be worse than the underlying problem.

Dr. Friedman (09:18): We want something that people tolerate well, that works well for them, and that's something they can count on. Other people are like, "Well, I don't want to take something every day." Now we have medications that you don't have to take every day. We have monoclonal antibodies that you could take once a month or once every three months. We have gepants, the oral CGRP drugs, one of which is dosed every other day.

Dr. Friedman (09:44): But again, I think it's — you kind of have to weigh the pros and cons — which is better: taking medicine every day or having migraine? People take medicine every day for lots of things, right? They take supplements every day. They take vitamins every day. People take medicine for blood pressure every day and other kinds of medical conditions.

Dr. Friedman (10:04): So I think it's just a matter of framing it correctly and maybe helping people realize that taking something every day is not always the worst thing in the world and it can really help them.

Carl Cincinnato (10:17): A lot of people are told that they have to be chronic to qualify for these treatments that are often on insurance and all that sort of stuff. And they may think, "Well, I don't actually have 15 days of migraine a month and so I wouldn't qualify." But the reality is, if you don't feel like 100%, if you have migraine symptoms of any level during a particular day, then that's a migraine day.

Carl Cincinnato (10:44): And so I think that many people don't realize that you can have this flexible discussion with your clinician to say, "Well, actually, let's reverse it." If I think about how many days where I'm just crystal clear — I'm golden, I have no symptoms, no headache — that's less than 15 [days] a month. I would definitely qualify. And I've already tried three treatments. I would qualify for almost any of these treatments. And so people think that they're not eligible. In many respects, they probably are, they just don't realize it.

Dr. Friedman (11:11): One of the limiting factors is actually — sorry, Richard Lipton — the MIDAS [Migraine Disability Assessment] disability scale. And I talked to Dr. Lipton about this because he came up with the MIDAS disability scale. It asks about migraine headache days. And I said, "When people are filling out the MIDAS score, should they include the days they have prodrome? Should

they include the days they have postdrome? That's migraine. It's still part of migraine, but you only ask about headache.

Dr. Friedman (11:40): And he just kind of looked at me and he said, "Nobody's ever asked me that before. MIDAS scale's been out for a long time." He said, "Actually, it was just devised for headache days. But I totally agree with you. Migraine is, of course, more than just a headache. And even after the headache goes away, most people are not crystal clear right afterwards. So it's definitely something that we should consider." And I think those should be considered migraine days.

Carl Cincinnato (12:06): Yeah. And I think most clinicians, when they hear our story as a patient, would agree with us and would work with us to give us access to that treatment if it meant that we were able to access it through the insurance, or however, and be eligible. How do the newer options like the CGRP monoclonal antibodies, the gepants, and neuromodulation devices — how do they fit into the preventive landscape?

Dr. Friedman (12:31): For most insurers, the insurance companies still control everybody's lives. There's been a lot of headway in the United States about being able to start with either the monoclonal antibodies or the gepants without having to step through a lot of medications. Sometimes that's good and sometimes it's not, frankly. But I know in other countries, that's not necessarily true, and you have to try the older things first.

Dr. Friedman (12:58): I see a fair number of patients who were started on a monoclonal antibody as their first preventive, often when those drugs first came out. And it's just like any other class of medications. The CGRP drugs don't work for everybody. So they may go through a couple of CGRP drugs and they're just not working. And we have to go back to the old stuff, which seems kind of backwards to me. But some of those old drugs actually work pretty well for a lot of people.

Dr. Friedman (13:29): So, even though I think that the tendency among headache specialists is to badmouth the old drugs, I think that a lot of them work very well in many cases. But the CGRP drugs certainly did change the landscape in a major way. And there were a lot of people out there who weren't getting a good response to the older preventives, and they didn't tolerate the older preventives, and their lives have been changed by the CGRP drugs. So everybody's a little different, but they certainly have made a tremendous impact on what we have to offer people.

Carl Cincinnato (14:01): So we've covered mistake number one is not optimizing acute treatment. Mistake number two is underutilizing preventive medications. Number three, we've got missing the hidden drivers of chronic migraine. So sometimes even with the right medications, migraine remains stuck in a chronic state, often because of the underlying issues that we may not think about. What underlying issues often go untreated and keep migraine chronic — like sleep problems, mood disorders, medication overuse, or neck pain?

Dr. Friedman (14:32): Sleep is very important. It's important for all of us whether we have migraine or not. But it is really important if you have migraine to have a consistent sleep schedule and to get enough sleep, and to make sure you're getting good sleep. And I'll tell you, we're all pulled in so many directions these days, it's really hard to do.

Dr. Friedman (14:51): So ideally, going to bed around the same time every night; being able to fall asleep, so like no screen time before you go to bed; waking up around the same time every morning, even on the weekends when it's fun to sleep in; and ruling out other sleep conditions like sleep apnea, for example, that can cause early morning headaches. But it also, I think, interferes with sleep quality in general.

Dr. Friedman (15:21): So, this can often be a process, and people sometimes need to go see a sleep specialist. Insomnia is a little different. The best treatments for insomnia are actually, the best

treatment is cognitive behavioral therapy. And people tend to load up on sedating drugs, and that's not always the best idea.

Dr. Friedman (15:43): Well, one that you didn't mention is seeing if the patient is taking another medication for another condition that causes headache. OK, because the side effect of almost every medication out there is headache, if you look it up. And it's really hard to treat a medication-induced headache when you're trying to attack it from the other side and get rid of the headache, but something's blocking your way. So that's another thing to look at.

Dr. Friedman (16:12): Mood disorders, we know that this is bidirectional. People with anxiety, depression, [are] more likely to have migraine, and vice versa. Other psychiatric conditions have been associated with migraine, like bipolar disorder. And there's no shame in the game, right? I mean, it's something that we need to address. And if it's causing the patient distress and causing problems, then the headache doctor needs to work on it, or whoever's taking care of their headache. And they may need to have counseling, or see a psychiatrist, or address it the proper way, just like we would address any other medical condition.

Dr. Friedman (16:48): What else? Good exercise. If you feel well enough to do it, that's helpful. Even going for a walk is helpful. Seeing the beautiful nature outdoors, I think, really makes a big difference, not just physically, but emotionally for most people. And again, just looking at various treatments and making sure that we're on the path, and making sure we have the right diagnosis, because that happens, too. Most chronic migraine evolves from episodic migraine, right?

Dr. Friedman (17:13): And there are a lot of reasons why that happens. But if people start with so-called chronic migraine from the get-go, I would say most times that's usually not chronic migraine. That could be new daily persistent headache [NDPH], that could be a CSF [cerebrospinal fluid] pressure disorder, it could be another secondary cause. And so, we really need to make sure that we have the right diagnosis before going down this whole road of trying multiple medications that may not be effective because we're not treating the right thing.

Carl Cincinnato (17:48): And we've done a whole interview together talking about: Could your chronic migraine be something else, and what those other things could be? So, for those people interested, we'll link that in the show notes. We also spoke briefly about medication overuse and neck pain. How might they be feeding chronic migraine?

Dr. Friedman (18:07): Well, neck pain can be part of migraine. And a lot of people mistake that for a second problem, right? There must be something wrong with my neck, because I get neck pain before I get a migraine. The neck pain is part of the migraine most of the time. But having cervical spine disease, especially in the upper part of the cervical spine, can lead to headache — not just migraine, but other kinds of headaches as well.

Dr. Friedman (18:33): TMJ, temporomandibular disorder, can also feed into headaches as well as migraine. There are definitions for medication overuse. And this continues to be a controversial subject. It has been, like, ever since they came up with the diagnosis many, many decades ago. So, the official criteria are that there is an increase in headache frequency that is associated with various types of analgesics and medications that we use to treat migraine.

Dr. Friedman (19:01): Almost every type of medication that we use to treat migraine can cause it, at least acutely, other than the gepants, which don't. Dihydroergotamine [DHE] very rarely does. Ergotamine tartrate can. But the simple analgesics, acetaminophen certainly can. The triptans can. Anything with caffeine — it doesn't even have to be medication; it could just be too much coffee — that can actually lead to medication overuse headache.

Dr. Friedman (19:33): And there are different parameters for the number of days per month of use that qualify for this. So, for opioids and butalbital, the official usage number — and triptans — is 10 days per month. Some people say butalbital, it really only takes four days per month. And then for simple analgesics and combination analgesics, like NSAIDs, it's 15 days per month. And it's actually debatable whether nonsteroidals [NSAIDs] cause medication overuse headache.

Carl Cincinnato (20:14): How would you advise patients to work with their doctors to address these invisible barriers?

Dr. Friedman (20:18): Well, when it comes to medication overuse, you need to be honest about what you're using. A lot of practices don't ask about over-the-counter medications. Over-the-counter medications are often not listed in the electronic health record as part of your medication list. So, you really need to kind of come clean about that stuff and be open. When you go see your healthcare professional, write it down. Go with a list.

Dr. Friedman (20:41): Make sure that you address the things that are the most important to you because we're all kind of pressed for time. We have people that are controlling our lives and telling us how many minutes we can spend with a patient, which is a sad state of affairs, but that's the way it is in a lot of places. And so, we have to make the most of the time we have. So, be up-front and be prepared, and make sure that you're ready so that you can get your issue covered.

Carl Cincinnato (21:16): I think that's great advice. Yeah, having a list even, of questions ready to go in with, and even potentially a support person there to help recall everything that gets said, because sometimes it's a lot. It's very condensed. Mistake number four: Overfocusing on triggers and underfocusing on thresholds. We can spend years chasing triggers, trying to eliminate everything that might provoke an attack, but sometimes the strategy backfires. What's the risk of an overavoidance or hypervigilant approach to triggers?

Dr. Friedman (21:45): You become a miserable person who can't eat anything that you want to eat and you're stuck in your house. I mean, really, there are some people that do take this to an extreme. And a lot of the things that are thought of as being triggers are probably not triggers. We know that during migraine prodrome, before the head pain starts, many people will get food cravings. And so, for example, the famous example is chocolate, which I always try to defend, being a chocolate lover.

Dr. Friedman (22:15): And for some people, chocolate is probably a real trigger. But for other people, you're not going to crave cauliflower, right? You're going to crave something good. It's going to be salty. It's going to be sweet. And then you say, “Well, I ate that and I got a headache. And so that caused my headache.” And that's probably not really what happened.

Dr. Friedman (22:35): There are things that have been pretty well established worldwide as being headache triggers — migraine triggers in particular. Heat is probably number one. People in hot climates, they tend to get more migraine. And in the hotter months of the year, people tend to get more migraines. There are certain food additives, and monosodium glutamate [MSG], and other chemicals that tend to be migraine triggers. Stress is definitely a migraine trigger. For most people, it's after the stress is over, but can also be during the stress.

Dr. Friedman (23:13): And there are legitimate migraine triggers. But I think there is a danger in becoming too hypervigilant. I mean, I know people that are just eating nothing but bland food, and they've given up everything they've enjoyed, and they never go out anymore because it's too loud. And we want people to live happy lives.

Dr. Friedman (23:28): And I think it really — that's worth a conversation in and of itself with whoever's taking care of your migraines. The other thing that I find helpful is [to] keep a good headache diary. You can do this online. There are lots of apps. You can do it on paper. For people that

think they have dietary triggers, I'll often have them do just a migraine journal for a few weeks. Write down every time that they get a migraine, write down everything they eat and drink, as specific as they can.

Dr. Friedman (23:55): Not necessarily how much. I don't care about that. I just want to know what. And I'll go through it with them and pick out stuff. Look, there's a pattern here, right? But often we find there's no pattern whatsoever, which probably means people can eat what they want to eat in those cases.

Carl Cincinnato (24:16): So another common problem is not having a comprehensive, structured plan, even if you've been managing migraine for years. In your mind, what elements make up a robust, long-term migraine management plan?

Dr. Friedman (24:27): Let's start, I guess, with acute therapy. So I definitely think that people should have options, right? So, if you could catch it early and you can stop it, OK, that's great. But if that doesn't happen, then we need to have option number two that you go to next. And hopefully enough options to use at home because we don't want people going to the emergency room — the worst place you can be when you have a migraine. So that kind of plan is important as well.

Dr. Friedman (24:59): On the prevention side, it's kind of similar, I guess, that if you feel like your medicine's wearing off, because sometimes that happens — people say with Botox, for example, or with the monoclonal antibodies, that sometimes at the end of the month or the end of the three months, they can feel it wearing off. So we need to have bridge therapy. We need to have other options to get people through.

Carl Cincinnato (25:24): And what are some early signs that show a plan is finally starting to work even before the symptoms improve significantly?

Dr. Friedman (25:35): Well, if you're a headache tracker, I guess you'll figure that out on your app or on your calendar. But I think that for many people, they're able to do things that they couldn't do before. And I hear that a lot in my office. People will come back and say, “I haven't been able to do whatever it is, in years. I haven't been able to go to a baseball game with my kids, right, in years, and I just got to do that.” Or “I haven't been able to go to a concert in years, and I was just able to do that.”

Dr. Friedman (26:06): And often their friends and their family members really notice the difference. You could tell when people are miserable, right? There's a certain look that people have. And all of a sudden, they're more engaged, and they just have a better — just a better appearance. And life is improving. So, like you say, I don't necessarily think that people need to get all obsessive about keeping a daily diary and recording what happens every day.

Dr. Friedman (26:36): But just noticing things that you could do that you didn't used to be able to do, I think, is a good indicator.

Carl Cincinnato (26:45): And mistake number six: Losing hope or losing momentum. For people who've been battling migraine for decades, the hardest part isn't always the pain. It's staying hopeful and motivated. What do you say to patients who feel burnt out or defeated after years of treatments that didn't work?

Dr. Friedman (27:04): I totally understand. It's really demoralizing. It's really upsetting. And for some of my patients, we go through treatment after treatment after treatment after treatment, and nothing is working. All I can say is that hopefully you have somebody who is taking care of you on the professional side, and have support on the personal side to keep you going, and to give your life meaning. And sometimes that is a spiritual thing.

Dr. Friedman (27:29): Sometimes that's just getting together with other people and not isolating yourself. It's hard. I get it. It's really hard. And we on the medical side and the scientific side are really working hard to understand migraine better and to bring better treatments to you. And unfortunately, it takes time, and there's a lot of regulatory things that slow us down. But for most people with migraine, to me, it's the most treatable disease in neurology.

Dr. Friedman (28:12): I don't know why every neurologist doesn't want to be a headache specialist. It's so rewarding to treat people with migraine because most of them get better. And I think that for some people it's a tougher road than others. But try to keep your spirits up because there's a lot of people that are in your camp and trying to help you.

Carl Cincinnato (28:37): I think that's such a good point you just mentioned, that the journey can be so different for different people with migraine and that even within this condition, this disease, it affects all of us differently. And I have nothing but compassion for people going through their own journey. Some people get lucky. They can have one or two migraine attacks in their life and never again. And other people can have resolution of an attack with a very basic over-the-counter treatment. And then you hear of other people who are just almost bedridden daily by chronic and debilitating attacks. And it can be so variable.

Dr. Friedman (29:11): Find a healthcare professional who really knows about headache and really likes treating headache. And they're few and far between, frankly. And work with them. And don't be afraid to take a preventive. I think one of the other things that sometimes people think about preventives [is] it's going to be a life sentence. The goal is not to have it be a life sentence. The goal is to make you better, and then hopefully you'll be able to get off some of it.

Dr. Friedman (29:42): Trust what your doctor or whoever's taking care of you is recommending because hopefully the science is backing us up. And interact with other people. I learn a lot from my patients. And in some ways, social media — that all drives me crazy. But in another way, some people come in and say, “Well, what do you think about this? What do you think about that?” And so I learn about new things from my patients. And I think it does help to interact with other people who have migraine.

Carl Cincinnato (30:20): Can you share a story or example of someone who turned things around and what made the difference?

Dr. Friedman (30:25): I would like to tell you about two people, actually. And I'm going to try not to give too much away because it's all personal stuff, right? But it's a mother-daughter team. And I first saw the mother because she had had a cerebral spinal fluid leak. And she was treated somewhere else and they fixed her leak, but she was still having headaches. And she really couldn't function. I mean, she was deconditioned and wasn't able to work.

Dr. Friedman (30:52): And so we talked a little bit about her headaches, and they really kind of sounded more like migraine. And I think she may have had a previous history of migraine. I don't remember for sure, but I said, “Why don't we treat you like migraine?” And she was having headaches more days than not. So we started her on Botox. And we also did nerve blocks. And it was like night and day. She got her life back. She's doing all kinds of different organizational work.

Dr. Friedman (31:22): And she is active again and social again. And it's incredible. Totally back to normal? No, but let's say 90%. She's doing well. Then she says, “Well, my daughter is having chronic headaches, and they’re treating her — the pediatric folks are treating her for migraine and she's not really getting better. And can you see her?” And a full disclaimer, I don't go out of my way to do pediatric headache. I have an adult practice, but it's her daughter.

Dr. Friedman (31:59): And so, I saw the daughter, and she had daily headaches and light sensitivity, and some other things that sounded like migraine. And she's a fabulous student, and was having trouble at the end of the day, concentrating during her last class. And it turns out that her headaches didn't come on until halfway through the day.

Dr. Friedman (32:27): She'd wake up feeling pretty good. And then her headaches would start later in the day, and she's got brain fog, and she's got light sensitivity, and, yeah, all these things can happen with migraine, but it's a really good story for a spinal CSF leak. And it turns out that both she and her mother have joint hypermobility, which is a risk factor. So I said, "I really think you have a leak." And the mother's looking at me because she's in the room going, "What?" Right? Because her mother had the leak.

Dr. Friedman (32:52): And so we sent her for an MRI [magnetic resonance imaging] of the brain, which did show changes that suggest she was having a spinal fluid leak. And she went and she had a nontargeted blood patch, and she was a new person. So, you know, you didn't have to make the right diagnosis. And sometimes it's hard. And sometimes it takes a couple of visits to really figure this whole thing out. But making the right diagnosis is so important.

Dr. Friedman (33:26): And it's really not that difficult to make the wrong diagnosis because sometimes there are just nuances in the patient's history that you don't always get the first time or even maybe the second time. So, I think it's important to really stick with it and make sure that you're on the right path.

Carl Cincinnato (33:47): Dr. Friedman, we did the numbers before. This was your 10th Migraine World Summit interview. I just want to say a huge, huge thank you on behalf of the team here at the Migraine World Summit, but also on behalf of our audience community. You've been so generous in donating your expertise, your compassion for us over the years. So, thank you very much.

Dr. Friedman (34:09): Well, Carl, I have to thank you because this was your brainchild. And I remember when you talked to me about it when you very first started it. And I thought, "Wow, this is going to be really great." And I hope you realize that it may have exceeded your wildest dreams. I can't tell you how many people come to see me that say that they watch the Migraine World Summit, and people who contact me from all over the world because of the Migraine World Summit.

Dr. Friedman (34:33): And there are so many people out there that have access now to really, hopefully, high quality education from experts from around the world that they never would have had before. And I think what you've done is just incredible. It's fantastic. I have just great respect for you, and congratulations for what you've done. It has made such a huge difference for so many people.

Carl Cincinnato (35:09): Well, thank you very much. The feeling is certainly mutual. And I do have to credit my incredible team of people.

Dr. Friedman: (35:14):

And your team.

Carl Cincinnato (35:16): We've got just an amazing team. I am standing on the shoulders of giants right now, even though you may not be able to see them. They are here and all around me. So, a big kudos to them. Thank you very much, Dr. Friedman, for joining us again on the Migraine World Summit.

Dr. Friedman (35:27): Thank you.