



INTERVIEW TRANSCRIPT

DISCUSSIONS WITH WORLD-LEADING EXPERTS

Told You're "Out of Options"? There's Hope

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Introduction (00:05): For some living with migraine, finding the right treatment plan can bring life-changing relief. But for others, it can feel like a revolving door — medication after medication, therapy after therapy — with little success. Hearing the words, "There's nothing more we can do," can be one of the most devastating moments in that journey. But it doesn't have to be the end of it.

Introduction (cont.) (00:24): Today we're joined by Dr. Lauren Natbony, neurologist and founder of Integrative Headache Medicine of New York, to discuss what happens when migraine becomes treatment-resistant; what paths still exist; and how to move forward with both support and hope. Dr. Natbony, welcome back to the Migraine World Summit.

Dr. Natbony (00:35): Thank you so much for having me. I'm really excited to speak on this topic.

Kate May (00:44): Thanks so much. This is such a challenging topic, particularly for people who might be living through it right now. So for those listening at home, please take care as you listen. Take breaks if you need and reach out to a support service or someone you trust if you want to talk it through.

Kate May (00:57): Dr. Natbony, thanks so much for joining us on this topic. You're an experienced neurologist, as well as an educator and speaker. Can you tell us about your work and what drives your interest in migraine?

Dr. Natbony (01:06): Absolutely. I am — as you said — I'm the founder and medical director of Integrative Headache Medicine of New York, which is my boutique practice in New York City, which really takes a very whole-person, integrative approach to migraine and care, and really does treat the most — what we say — refractory or chronic patients. What drove me to this was personal. I feel like anything that you love and are passionate about usually comes from a place of personal experience.

Dr. Natbony (01:34): So I think I've said this before, but growing up with a mother with migraine, it was a lot. And I was really the one who had to help her and guide her and take care of her. And then looking at myself developing symptoms of migraine over time, [it] really just became a journey. And it really drove me to want to understand the brain. And then once I wanted to understand the brain, then I really was just like, headache; I really want to understand headache.

Dr. Natbony (02:01): But also, there's so much we don't understand. And I think that's part of the draw to it but also the frustration. And I was keen on really figuring out, “What can I do to help people when they feel like there's nothing left and there's no more hope left?” And that's where I really find my place in this field.

Kate May (02:19): Fantastic. Sounds like you're very well-placed to help guide us through this topic. And I also grew up in a house where my mom had migraine, and I developed migraine. So it's such a relatable journey that we see all the time. So thanks so much for sharing that background as well.

Kate May (02:32): So we know that migraine is this complex disease. Some people may easily be able to find the right treatment and support for them, but others seem to just hit dead ends. And we know that many people in our community describe trying lots of different treatment options and perhaps being told that there's nothing left to offer. From a medical perspective, what is treatment-resistant or refractory migraine?

Dr. Natbony (02:52): Treatment-resistant means that you are still having significant disability despite trying multiple appropriate preventive treatments at the right dose for the right duration. And refractory is basically that far end of the spectrum when attacks remain so frequent and severe despite really trying myriad medications and really careful management of triggers and comorbidities. It's



really when people are like, "What else is there? What else is left?" And that is a really hard place to be in. But there are lots of different ways to approach it, which I'm sure we will talk about.

Kate May (03:28): Yeah, absolutely. And how do you know if it's a refractory migraine or just one that hasn't found the right management yet?

Dr. Natbony (03:35): The most important thing is — I would say to trust no one, but to ... because I don't trust anyone else's diagnosis except for my own — and the phenotype of the pain. So if someone comes to me and they're refractory and they say that they've been diagnosed with chronic migraine, obviously I do not doubt them. I just always look at: Is there something else that is there, or is the diagnosis 100% correct? Because you can have migraine that then morphs into new daily persistent headache [NDPH]. There are other layers of diagnoses there that can be important to tease out. And I always like to do that and just basically start with the foundation, make sure that there are no missing diagnostic pieces.

Dr. Natbony (04:16): Then I always want to make sure that the medication trials that have been done were actual trials, because how many times do I have people come in with a list of 50 medications that were tried at the lowest dose and weren't tolerated? And for that, I say, "The good news is you really haven't tried anything." Like, you've tried it, but it hasn't been done at the appropriate dose for the appropriate duration. So we really can't gauge any efficacy or say that it didn't work; it just wasn't able to be tried.

Dr. Natbony (04:44): And I think that the third one is also setting expectations as to what does success mean? Because I think there's a goal of we want everything to be better and gone. And then there's, "OK, what is a realistic first step, next step, and last step?" But I think it's really reframing what treatment means and what the end goal is in order to figure out what then success means.

Kate May (05:09): Yeah, great. That makes sense. And how would you think about it from a patient perspective? How would you know if you've exhausted all options or it just might be about finding a different approach or retrying something?

Dr. Natbony (05:22): So I will say when patients come to see me, I have this huge questionnaire that literally is 41 pages. OK, it's a little bit ridiculous, but it lists every single medication that I could think of — actually, I have to add a few more — but that I could think of that can be used for migraine. And what patients say to me is, "Oh my gosh, I thought I had tried everything, but then I looked at your list and I realized I have not tried much of anything."

Dr. Natbony (05:49): So my approach is always to say, when someone first comes in, "Look at all of this." We check off the boxes. Then we're like, "Wait, there's a whole lot left." I make them fill in the dose. I show [them] what is the average appropriate dose. I'm really framing what they have tried in the context of what is out there.

Dr. Natbony (06:07): And also I talk a lot about layering — using a layering approach — because just because you tried one treatment in isolation 10 years ago, doesn't mean that that same treatment now layered onto another treatment that works synergistically won't then be beneficial. It's always that something that didn't work in the past might not have worked in the past, but it doesn't mean it's not going to work in the present under different circumstances.

Kate May (06:31): Yeah, fantastic. I think that list sounds like a really useful tool. It's very hard to remember all those things or to piece together medical records on your own. So I think that would be a fascinating and useful tool. And I also love the idea of layering. I'm sure that that gives some options where you might think that you've exhausted something before, but perhaps it could work in combination with something else. I think that's great.



Kate May (06:52): So it's an incredibly hard situation for people with migraine to feel like there's nothing left that can help their symptoms or they've thought that they've tried everything. As a clinician, when someone is in front of you who clearly feels or has been told that they're out of options, what's your approach to move forward?

Dr. Natbony (07:07): My first approach is I set one goal and I say, "OK, let's put aside that we're out of options. I want to know what is the most important thing to you right now to be able to achieve if you can leave here today: Do you want to be able to go running outside? Do you want to be able to go to a concert? Do you want [to] just be able to be present for your family? What is that one goal we can provide within the next X amount of time, so what is that — the next month?"

Dr. Natbony (07:32): And then talking about the different strategies and ways that we can achieve that and setting that really short-term goal. Because I feel like when someone comes in, they're like, "Nothing works, nothing's ever going to work." It's a feeling of dread and doom, and it's really hard to move past that. So I always like to say, "We're going to start with one small step, and then we will gradually build upon that, but that there is never nothing. It's just we haven't uncovered it yet."

Dr. Natbony (07:57): It's that there is so much, but it's just basically pulling those layers and unwrapping those layers and figuring out what you need as a person and finding that because everyone has a lock — their key just might be a little different or their — it just might be a mismatch and we just have to find that perfect pairing.

Kate May (08:16): Yeah, brilliant. I love that metaphor and that idea of a lock and there are certain pairings or keys that exist, but it's finding them and finding the combination. That is that incredibly challenging journey for some.

Dr. Natbony (8:28): Yeah.

Kate May (8:28): Yeah, fantastic. So you have a background in integrative headache medicine. Can you explain what this is?

Dr. Natbony (08:34): Integrative headache medicine is something that I sort of came — it's sort of my own making, with my training of headache medicine. I'm also a licensed and trained acupuncturist, and I also pursued advanced training in lifestyle medicine. So putting that all together is, you take basically the best of the conventional medicine that we have with headache, and then you offer in lifestyle medicine, lifestyle adjustments that are all evidence-based.

Dr. Natbony (09:03): Again, everything I do is evidence-based, so integrative does not mean that it's not evidence-based. And then basically plugging in all different body systems. So I look through the whole body and I say from top to bottom, "What here do we need to target?" "Are there any mind-body therapies that can be helpful?" "Have we looked at sleep?" "Have we looked at thyroid?" "Have we looked at the endocrine system?" "Have we looked at the cardiac system, the autonomic system?" "Is that part of the picture here?" "What about the gut and the GI [gastrointestinal system]?"

Dr. Natbony (09:32): And how those all play a role in forming the person and where they are today. And then seeing how we can intervene in each aspect to make everything kind of come together and be better because we know everything is connected. So my — again — finding that missing piece and that missing link is by looking at all those different systems in combination.

Kate May (09:53): Yeah. Brilliant. You've touched on a few different, I guess, diagnostic pathways or treatment or alternative treatment options. Can you talk us through some more — what are some actual alternative or complementary treatment approaches that can be layered or tried?



Dr. Natbony (10:07): So acupuncture is one of the ones that I had mentioned. I think acupuncture is good for layering. It has the most evidence for episodic migraine prevention, but really can be helpful for chronic migraine in the right patient. I find that, again, layering things can be helpful. I also really like the whole practice of self-modulation and feeding back and self-regulation, which goes into biofeedback and basically the neural feedback onto your own system.

Dr. Natbony (10:39): So I always recommend those basic ... I'll choose either this person I think will be a better acupuncture candidate because, you know what, just got to just quiet things down and give them a little bit more of the body connection. Or I'll go more with recommending biofeedback or vagal nerve feedback and trying to modulate their autonomic nervous system. That's one of my first proponents that I go for.

Dr. Natbony (11:08): Everyone — I know it's not necessarily complementary — but everyone gets a sleep evaluation. That's what I talked about at my last Migraine World Summit was sleep, because I think that's very often overlooked. And even though it's not complementary per se, it is part of the whole lifestyle picture into how somebody is sleeping, what their sleep schedule is like, and if there are any ways we can intervene to improve sleep.

Dr. Natbony (11:32): I then also look at supplements. I think that supplements are something that we hear about so much. I will say, by the time that patients get to me and are refractory — I like supplements, but they usually aren't what I will recommend adding in necessarily at that moment to change the whole picture. But they are something I layer on for gradual improvement. Those are where I usually start.

Dr. Natbony (11:58): And then I also look at musculoskeletal. Are there any musculoskeletal components? Would somebody benefit from something like physical therapy or targeted massage, tai chi, yoga, like an actual graded exercise program? Because exercise, again, is something that is really helpful and that I look to layer on as well.

Kate May (12:18): Brilliant. And what about — I know you mentioned lifestyle and sleep and perhaps movement. What other things might you be looking for there under lifestyle and what options could people have moving forward?

Dr. Natbony (12:29): I look a lot at patterns, something that I have people track. I know nobody really likes to track and it's hard to track, but looking at patterns of stability, because as my favorite phrase is, "The migraine brain likes stability." And when things become unstable, it kind of goes haywire.

Dr. Natbony (12:45): So I try to focus on the key lifestyle habits that will promote basically a stable migraine life, which is same wake and sleep time; trying to eat within 30 to 60 minutes of waking up; eating small meals with protein every three to four hours throughout the day; talking about starting the day with a good amount of hydration; and then making sure that you are keeping up on your hydration throughout the day.

Dr. Natbony (13:10): Again, hydration does not cure migraine. I feel like that's something that is always like, "Drink more water." It's just maintaining stability of the balance of water in your body, that's important. I say, if you're going to use caffeine, have the same amount of caffeine at the same time every day.

Dr. Natbony (13:28): And to make sure you are getting physical activity. A lot of times as a migraine person, you don't want to exercise when you don't feel great. But I think that once that part goes or slips, it's a slippery slope to where you're not getting much movement. Other things start to hurt. You start getting more neck pain, shoulder pain, because the body is inactive. So making sure that there is some physical movement in every part of the day.



Dr. Natbony (13:52): I also tend to look at nutrition patterns. For example, I had a patient who would always wake up in the middle of the night. And there are many different reasons for waking up in the middle of the night, don't get me wrong. But she'd always wake up a little bit hungry, and that would develop into a migraine. So I had her track her nutrition, what she had during the day, and we built in to see that her blood sugar levels leading up to the night were falling. And we needed to put in a protein-rich snack before bed, but not too close to bed, so it wouldn't make it hard for her to fall asleep.

Lauren Natbony (14:24): Just really changing those nutritional goals throughout the day really did help with that overall hunger cue, hunger pattern that then triggered a headache. So it's again really looking at someone's individual patterns to make stability for stabilizing energy and calming the whole system.

Kate May (14:41): Fascinating. Thanks for that example. I'm sure it's different for every person that comes in based on whatever factors are going on in their life.

Dr. Natbony (14:48): It's so different. I think that's the challenge is [that] what works for one person doesn't necessarily work for the other person. And it makes it extremely frustrating. I can totally relate to that.

Kate May (14:59): Yeah, absolutely. I'm sure those listening can absolutely relate to that. But it's great to hear some individual examples and how things can get moving or options can open up. I'd like to move on to chat about medication overuse. Can you explain what it is and how it develops?

Dr. Natbony (15:14): Absolutely. So medication overuse happens when there's frequent use of acute treatments that basically keep the system and the pain system sensitized, and it leads to more frequent headache. So medication overuse and medication overuse headache [MOH] are not the same thing. In order to have a diagnosis of medication overuse headache, there needs to be a chronic headache, meaning 15 or more days a month of headache for more than three months.

Dr. Natbony (15:40): And then there needs to be more than three months of use of either triptans, opiates, combination analgesics, simple analgesics like NSAIDs, acetaminophen. Basically in combination, there are different thresholds, but usually we say 10 days a month combined. So if you are using eight days a month of a triptan and then seven days a month of a nonsteroidal anti-inflammatory [NSAID], that would be more than the limits for where the brain then starts triggering more pain.

Dr. Natbony (16:12): But it doesn't happen immediately. It's not something that like, "OK, this month I used too much this month, and this is going to lead to a medication overuse headache." You can be one month overusing, per se, medication, but it takes time to develop into a medication overuse headache. And different medications have different thresholds. For example, some of the worst offenders are the combination analgesics — the ones that contain caffeine, acetaminophen, aspirin.

Dr. Natbony (16:41): Then we have the butalbital-containing compounds, which tend to cause more risk of medication overuse with lower frequency amounts. Opiates, for example, tend to be a greater offender. But it really is just saying, "I have a 10-day-a-month threshold for these medications and trying to keep it below that."

Dr. Natbony (17:00): That being said, when the gepants were approved and came to market — so rimegepant [Nurtec, Vydura], ubrogepant [Ubrelvy] — that really changed things for us because those types of medications are not thought to contribute to medication overuse headache. So it opened this whole pathway of, "We can treat acutely more frequently and not cause oversensitization."



Kate May (17:21): Fascinating. So the space is really changing. That's great to hear. How do you approach managing medication overuse in someone who has that daily migraine?

Dr. Natbony (17:30): It's a very, very complex and tricky question. Again, I will say the newer medications have revolutionized that because before the CGRP — the monoclonal antibodies and the gepants — there was nothing that really worked quickly for prevention. It was all, “We have to start at a lower dose, build up over time, and we have to wait to see improvement.”

Dr. Natbony (17:50): But now my approach is usually, first, to educate the patient as to what's going on, talk about how we have to cut back on the overused medication, and start max prevention right now. There are some practitioners out there who are like, “We'll start one thing and then we'll start another thing.” For me, I'm like, “We're going to stop the overused medication. We're going to start optimal prevention and create a bridge.”

Dr. Natbony (18:15): So for example, I'll say, “You're stopping tomorrow your overuse of whatever medication. We are going to start with a CGRP monoclonal antibody injection. I'm going to bridge you for the worst of the withdrawals.” So there is some withdrawal from stopping overuse. It depends again on the substance that's being overused. But I will use, for example, a seven-day course of steroids, nerve blocks, infusion therapy, to sort of make this bridge. So that way it bridges from when the brain is coming off of that medication.

Dr. Natbony (18:47): And then I will replace the acute medication with more appropriate ones — so swapping them out. So I always give a three-tiered approach: a mild, moderate, severe. So if someone then has mild pain, my first go-to is always a neuromodulation device, just because it can't be overused. They are something that — I don't know — I just feel like they're an underutilized tool because it's not causing overuse. It can help. Yes, it may progress, but it might also be enough. I think a lot of times we treat because we're afraid that it's going to progress, not necessarily because it has progressed to that point. So putting that first layer in is helpful.

Dr. Natbony (19:31): Then I will have a moderate. If the pain gets to a moderate level, that might be where I'll say, “OK, we'll do a gepant.” And then if it gets to a severe level, I will then use a different class of the medications that were overused before. So for example, let's say they were overusing an NSAID, I'll put in a triptan to be used up to 10 days a month. And that would give them something then to use pretty much every day.

Dr. Natbony (19:54): And then I have my fail safe, if all else fails, here's the emergency backup. Because I think a lot of it is managing the anticipatory anxiety over not having something. So if you have multiple options and a written out, graded plan, I think it does take down the anxiety over now stopping what you're so used to and so comfortable with.

Kate May (20:16): Yeah, brilliant. Thanks so much for breaking that down and explaining how you would approach that and some of the different options there. I've got a question from our community: Olivia and Karoline describe feeling confused by conflicting advice in migraine management. For example, take triptans as soon as you feel a migraine coming on, but also don't take too many in a month. What's the best advice on triptan use and what can you suggest for someone with frequent migraine who feels like they need to use more than advised?

Dr. Natbony (20:43): It's a great question — and that must be so, I can only imagine — I'm hearing that question, I'm like, “I'm confused as well.” I would say anyone who has lower frequency episodic migraine, so less than eight migraine attacks a month, this really isn't as much of an issue because you can treat every single one of them early and you won't reach that threshold of the 10-day-a-month limit.



Dr. Natbony (21:07): The problem comes when the frequency gets higher and then you have to pick and choose. And at that point, it is a "When do I use the medication? What is early enough?" And I basically say, "This is not going to really turn out well. We need to work on better prevention to lower the frequency. Because you're right — we're not going to be able to say when to use it —when is early, when is too late.

Dr. Natbony (21:31): I will usually say you're going to pick three days a week on average. You're going to say, for example, "On three days a week, starting from Sunday to Sunday, I'm going to start with the triptan as soon as I feel something. I'm going to repeat after two hours if the pain isn't gone. That is my plan. And if I then need something in between those three days, I will then use a different treatment like a gepant."

Dr. Natbony (21:57): You're right. It's a catch-22. You can't treat early and treat aggressively when you're having too many attacks. So that's why it's kind of like — you just can't. So I think that's why it's conflicting advice because there is no great answer there. It's finding a strategy. We're maintaining a threshold where you will treat, but also giving other options.

Kate May (22:18): Brilliant. I like the idea of setting the days. I think something structured or rules around it can sometimes make managing those tricky decisions [easier]: Do I take one? Do I not? Am I overusing it? Am I under? That sort of thing. I think having a structure or a plan going forward that's right for you sounds like a great way to approach that question.

Kate May (22:37): People who live with unmanaged migraine can face some pretty big challenges in navigating the health system and getting the support they need. I've got a few examples from within our community that I'd love to workshop with you and get your thoughts on. So Mike from our community says he feels like he's constantly bouncing between doctors who don't communicate and he's always starting from scratch. What practical advice can you offer to help people manage their own care that improves communication so they don't fall through the cracks?

Dr. Natbony (23:01): Love that question — because that is why I started my own practice, because I needed the time to be able to coordinate with other practitioners. And even now with that time, it's still really hard. Getting in touch with other doctors and collecting all that information is a challenge. And I would say even me as a patient, I realize I haven't done that for myself and I'm now going back and trying to collect all that data.

Dr. Natbony (23:25): But I think that the most important things are, after a visit with each doctor, trying to get a summary of it. Most larger medical systems now allow you to print out the notes from the visit either on the portal [or] you can request them. And then keeping a binder of those notes and then perhaps keeping a list of medication trials with dates and doses is really helpful.

Dr. Natbony (23:51): And I think it really is on the patient, unfortunately, to really have to put all that data together and present it in a nice package to the doctor just because what we don't have in front of us, we can't possibly know. And I will say, coming in a small practice that I don't have connections or I didn't have connections to any of the larger medical system records, I would either have to get it from my patient or I would have to then go and search for it myself. And yes, that is something that I do because that's what I do in my practice, but it's hard and it's not something that is easy to navigate.

Dr. Natbony (24:31): So that was a lot of words. The main thing is, be your own advocate. There are now apps. There are a few apps that help you to put all the data together, that it will actually pull it from different medical systems and put it into one folder. I would say keeping your own records, asking for a copy of every single note, every single lab order, and keeping them and bringing them with you or having a disk drive with it — something that you can share is important.



Dr. Natbony (24:54): And then not assuming that doctors are going to necessarily communicate. It sounds horrible, but I feel like the assumption is, "Oh, you must have talked to my doctor. You have these lab results. You know this. You knew that." Assume that none of that is common knowledge. And I think it will just be [that] expectations are a little bit less, that you need to be the one who is facilitating that communication.

Kate May (25:15): Yeah, fascinating.

Dr. Natbony (25:15): I feel horrible saying all that, but I think that it's hard. There are so many pieces. And I even think about myself when I've been trying to reach this one doctor for one of my patients now for weeks: I leave messages; I send emails; we can't coordinate a time; and then something comes up. And then when you have that with a lot of patients trying to do that for everyone, it's really challenging.

Kate May (25:38): Yeah, it's great to hear that perspective as well — because most people will come into that from that patient perspective — but it's great to hear the challenges of that from the doctor perspective, as well.

Dr. Natbony (25:46): I do want to say I spend a whole day every week. So I spend a whole day every week just coordinating care — not seeing patients — just literally sitting and emailing other doctors, talking to other doctors on the phone, trying to get records, trying to put the records together. And that is a full-time job. And it's not something that an insurance system pays for. And it's not something that you are incentivized to do in a medical system because it's not bringing in the numbers, but it is what really helps shape and form overall treatment of a patient. And that is what I feel is missing a lot of times from our treatment system.

Dr. Natbony (26:24): But just know that the doctors, not that we don't want to help, like we do want to help. It's just there are limitations in what we can do. So bringing us that information is always the most beneficial thing.

Kate May (26:33): Yeah, great. I think that's really good to know. I certainly wish I knew that perspective before going into my own migraine experience because perhaps I would have kept better notes.

Dr. Natbony (26:41): I went to a doctor's appointment last week and I was like, "Why didn't I keep better notes?" Like as a doctor, I'm like, "Where are my notes?" Because I'm all over the place. So it happens to all of us.

Kate May (26:51): Yeah, absolutely. It's very relatable. I've got another question for you. So Raelene lives somewhere where newer treatment options like gepants or neuromodulation devices aren't yet available. What advice do you have for people in smaller or less resourced areas?

Dr. Natbony (27:06): I will say that I have done many talks and trying to educate around the world, but I don't know what treatments are available in different places. It's figuring out, what do I have here in my country that I can access? Are there any online tools that I can access now with online care, online therapy? What is the first place that I need to start? So resource-wise, if you don't have access to neuromodulation or to gepants, what about the basics before we had any of that?

Dr. Natbony (27:35): Sort of going back to, "OK, what is my foundational piece, which is lifestyle and routine and exercise and sleep? Let me work on those first." And then saying, "Of the medications available, what can I try? What can I try in combination and layer?" And then if it's not available to you there, it should be hopefully at some point. But is it possible to travel outside of that area to get it? That's something that I don't know, but it must be extremely challenging if you don't have those resources — especially to be in a country where you don't have access or in a really rural



area — because I can give you all of the advice in the world, but implementing it does depend on what is accessible.

Kate May (28:16): Yeah, absolutely. I'm sure it must be very frustrating if you hear a new treatment's available but can't figure out a way to access it personally. This actually feeds into my next question. I've got one more hard question for you: Jennifer from our community describes getting her hopes up for new treatments, only to have it fail, or worse, have to stop it because of side effects. She says she feels like her body's betraying her. How do you help people through this emotional side of a failed treatment, getting your hopes up and it perhaps not being what you wanted it to be?

Dr. Natbony (28:44): So I have this one patient who we waited so long for the new treatment — so long. And she was resistant to trying it. She was like, "What if this doesn't work? It's my last hope. It's my last hope." And to be honest, it didn't work and she had side effects. And it's sort of that same place. What I say is, CGRP for example, is only one chemical in the brain. It's only one of so many that we have. And not everyone is going to be a responder to it. And just because you didn't respond to it doesn't mean that you're not going to respond to something. We just haven't found that something yet.

Dr. Natbony (29:20): I will say most patients who are chronic and who have trialed lots of therapies aren't going to respond as well to the therapies that we have now. But it doesn't mean that it's not going to be better in the future. And it also doesn't mean that — also, again — with layering, also changing doses ... I think with side effects, a lot of times it's getting through the initial side effects that can also be helpful. I think it's saying that just because this didn't work for me doesn't mean that my body failed. It's that the medication failed *me*. It just wasn't specific enough for what my body needs. And that's not a failure of *you*. That's a failure of our system right now and science.

Kate May (30:01): Fantastic. I love the reframing of failure because it's not a failure of the individual. It's a failure of the medication and flipping around that heavy feeling, feeling like you've failed or your body's failed. But actually, it's quite external that that particular response has failed. So I love that particular reframing of where that failure is coming from.

Kate May (30:20): I'd like to end the interview on a few more questions about hope and resilience and managing how we might cope with something like this. What strategies can you recommend for coping with treatment-resistant migraine and what can people really do in those moments?

Dr. Natbony (30:32): I've been thinking a lot about this — and as you're talking about the reframing — I think that a lot of times it is reframing the "nothing works." What does it mean to work? What does it mean to have response to something? Because I think that a lot of times we think to have response to treatment means that we are pain-free or that we are somehow in a place where we are so much better than we are now.

Dr. Natbony (31:01): And I'm not saying that it's not going to get there in the future, but I think it sets people up for failure to think in these great absolutes. So I think the hope is that there will be something. It's just not right now at this moment today in time. I don't know what next week is going to bring. I don't know what three months from now is going to bring. I don't know what eight years from now is going to bring. But there is always hope for more. It's just we have to keep digging deeper into why what you're doing right now isn't working perfectly for you.

Dr. Natbony (31:34): And reframing is hard. I have a hard time with it every day. And what I remember in the beginning when I used to — back in the day of being a baby doctor — when I used to send people for biofeedback and just feedbacking on their own pain systems. And I was like, "I don't ... I don't get it. Like, I don't understand how I'm supposed to just sit here and, like, feedback and teach my body to calm itself down." Then over time, I started to do it and realizing we have more control and more power than we think that we do.



Dr. Natbony (32:06): And that's ... I haven't talked about the autonomic nervous system, which is something that I always talk about. But our body is resilient and it wants to heal. We just have to give it the right tools in order to do that. And I frame it as saying, "I'm here to help you and guide you to find those tools and we will find them. It's just not going to be an easy journey." But nothing that is ever successful or fulfilling is ever easy. But it doesn't mean that it's not possible.

Kate May (32:31): So I know that you live with migraine yourself. How has ... what's your own experience taught you about migraine and what have you learned from that?

Dr. Natbony (32:38): Everybody is different. I sit there. So I make that same decision of, "Do I treat? Do I not treat?" My husband actually yells at me. He's like, "Just take something!" I'm like, "But it's not that simple. It's just a regular headache. It's not going to be a real migraine." I'm like, "What ... what am I doing?" So I think that a lot of times what goes through a patient's head goes through my head every day. Even as an experienced headache doctor, I still don't have the answers.

Dr. Natbony (33:04): I will still sit there and say, "Is today an acetaminophen day?" "Is today a rimegepant day?" "Is today a triptan day?" I don't know. Your guess is as good as mine. But what I realize is if I'm wrong and I get it wrong, it's OK. Like, it's OK. And I will bounce back and I will figure it out for the next time. But sometimes there are no answers. It's just trying and doing the best you can in the moment.

Dr. Natbony (33:23): And I think that's what I've learned, especially with having a family and having kids. What we say, "Guys, I have to go. I have to go lay down." They're like, "Does Mommy have a migraine again?" And it's not like this little thing that they bring me, like a little ice pack. They bring me some water. They tuck me into bed. And it's realizing that migraine not only affects me as a person, it affects the whole family. It affects everyone around you.

Dr. Natbony (33:50): And I just think I've learned to be mindful of that and to be mindful of how I interact with my patients and seeing them not just as a person with migraine, but as a mother, a wife, a business person, or whatever else they're doing in their life. Migraine doesn't necessarily define them, like it doesn't define me. It's part of who I am. And I have to say I'm proud of that because it allows me to be the person that I am. And I would say to everybody else, migraine doesn't define you in a negative way. It allows you to be resilient and allows you to have experience and depth. And I've learned you have to embrace that and we can really help each other with that same attitude.

Kate May (34:31): Fantastic. That's a lovely reflection. Thanks so much. I'm sure that will be well appreciated by those who are listening on and looking for that, I guess, grounded response combined with a medical response. I think that's really fantastic.

Dr. Natbony (34:42): It sounds a little bit preachy, but I think I have dealt with a lot of struggle, and I think we've all dealt with a lot of struggle. And I think seeing it from the other side is obviously a lot easier than when you're going through it. But I just want everyone to know there can be another side. And yeah, I just don't want anyone to ever give up and feel like there really is nothing left because there is always something.

Kate May (35:07): For those listening today who are at the point of feeling like there's nothing left to try, what would you want them to most hear?

Dr. Natbony (35:12): There is never nothing. That medicine and science is constantly evolving. Just because we don't have the answer today doesn't mean we won't have the answer tomorrow. And even if we don't have the answer — the cure — there are treatments that can be tried and tried together. I have seen a lot of patients in my time. And again, I'm just one person. But the amount of times I have seen people who said they have tried everything, nothing works. It's, again, reframing it to: Maybe things work together in combination. Maybe I need to think a little bit outside the box.



Dr. Natbony (35:44): And I think continuing to advocate for yourself and saying there is never an end to what is possible. Continue searching for it and really just never give up finding a doctor that aligns with you and aligns with your goals. And knowing that it's just as much of a journey for the doctor as it is for you and finding that relationship and partnership where you can really work together because there is hope and there is light at the end of the tunnel.

Kate May (36:08): Thanks so much. And thanks for everything you've shared today, Dr. Natbony. It's been fantastic to hear all those different options that can be going on and really having a grounded look at that experience of refractory or treatment-resistant migraine and how [there may be] different ways you can approach and layer it. I think there are lots of different options to consider and hopefully will be well appreciated by those listening along at home who are perhaps going through that experience themselves.

Kate May (36:32): If someone is wanting to learn a little bit more about this topic or learn a little bit more about your work, can you put them in any direction where they could look at more resources or find out a bit more about integrative medicine or anything we've talked about today?

Dr. Natbony (36:44): So my website, which is integrativeheadacheny.com, is all about me, my work, and other resources there. You could also follow me on Instagram: [@laurennatbonymd](https://www.instagram.com/laurennatbonymd). Those are really the best ways. And yeah, if anyone ever wants to connect, feel free to message me or reach out on social media.

Kate May (37:08): Perfect. Thanks so much. And thanks again, Dr. Natbony. We really appreciate your expertise and your reflections today.

Dr. Natbony (37:14): Thank you.