INTERVIEW TRANSCRIPT

DISCUSSIONS WITH WORLD-LEADING EXPERTS

Stopping Migraine Preventives: When, Why & How To Transition Off Safely

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Introduction (00:05): For so many in our community, the primary goal in migraine management is creating a plan that works to reduce migraine's impact on our lives. If that includes a preventive medication, the idea of ever stopping that med can feel challenging. And yet this year, one of the topics our community most wanted to hear about was just that — how to transition off a preventive medication.

Introduction (cont.) (00:29): This speaks volumes about the hope and progress being made in migraine care, but it comes with big questions and understandable fears. Today we are joined by Dr. Matthew Robbins, a leading headache specialist, to guide us through this important conversation. We'll explore when, why, and how someone might safely reduce or stop their preventive medication after a period of success on it. Dr. Robbins, welcome back to the Migraine World Summit.

Dr. Robbins (00:56): Thank you, Elizabeth. So glad to be here with you.

Elizabeth DeStefano (01:00): So, I want to first acknowledge that reducing or stopping migraine preventives may feel like a distant, maybe even unimaginable, goal for many people with migraine. And yet we know for others, it's very fortunately where they are right now, and that's a major milestone. So, here today, let's equip people with the knowledge that they can use to embrace this step if they're on it, or to plan for it if it's one they're working towards. So, to start with, what are the primary reasons that someone with migraine would ever consider stopping a medication that has worked well?

Dr. Robbins (01:40): Well, I think first of all, it's so great that this has been a popular topic because it goes to show you that people are doing presumably great on preventative therapy and have questions about how long they need to be on it. And my approach is typically to have that conversation when you start someone on a preventative therapy and set up the expectations in the beginning.

Dr. Robbins (01:58): Because for a lot of people with migraine — they're younger, they could be teenagers, they could be adults, they could be healthy, they might have other medical issues — but this might be the first time that they're on an everyday medicine in their lives. And it's a big question: "Am I going to be on this — taking an injection, taking a pill — every day for forever?" And what's the expectation?

Dr. Robbins (02:19): So, I think always at the beginning of starting a preventative therapy, it's great to lay out those expectations. And there's many reasons why someone, of course, would be started on a preventative therapy, but there's also many reasons why it could be stopped. And the most optimistic one, and the one that I always like to talk about first, is that it's working great and you're doing really well, and your life with migraine is in a much better place.

Dr. Robbins (02:43): And therefore, we should always reconsider at that point about the need for such preventative therapy or the need for a certain dose of such preventative therapy in the long run. And then the other major factors might be, well, maybe the preventative therapy is not working, and of course, there should be a change, or it's causing side effects requiring some sort of change. Or is there some life circumstance that suggests that we should take it off for a safety reason?

Dr. Robbins (03:14): You know, such as people who are considering pregnancy, or if there's some other health issue that has come up that requires a pivot in preventative therapy for some reason. So, I think there's reasons that include people doing really well, people who have life

circumstances that might dictate the need or the indication to reduce or stop a treatment, and also issues about tolerability and side effects.

Elizabeth DeStefano (03:45): Is the goal of preventive treatment always to eventually stop when you're talking about employing one in migraine, or is long-term treatment with a preventive perfectly acceptable?

Dr. Robbins (03:58): Well, I think both. I think thankfully we're in an era where there's so many preventative therapies that their long-term use has proven to be safe and effective. So, I think we're in a really good place with migraine prevention for many people, where continuing on treatments has been easier to do in recent years because the treatments have just been more tolerable, have fewer side effects, and potentially work better. That's not the case for all preventative therapies, but I think that is the case for many of the newer ones that we are using.

Elizabeth DeStefano (04:26): When you are considering with a patient stopping or tapering a medication, how do you weigh that balance between the potential burdens of using a preventive — whether that's side effects or costs or hassle — and the benefit of continued known stability?

Dr. Robbins (04:46): It's a great question, and it fundamentally addresses this question of: Do preventative therapies for migraine modify migraine disease? Do they make the disease biology more quiet, or do they just suppress symptoms? And that answer remains pretty much an open question.

Dr. Robbins (05:06): If we thought that they modified disease, then what we would see is that when we would wean off a preventative therapy, a remission would be induced in a sustained way because they've induced some changes in the brain or networks in the brain or structures in the brain that migraine was responsible for, and it undoes some of that biology that we do not like. But the studies haven't really proven that for sure.

Dr. Robbins (05:34): The studies have really shown that most migraine preventative therapies when they're stopped, people may get a little bit worse, but typically don't get as bad as they did before they started the preventative therapy. Now that could just be because we don't follow people in these studies long enough to see them regress to where they were before, but it's also really a completely mixed bag. Some people have a great prognosis coming off of preventative therapy.

Dr. Robbins (05:59): Some people may revert back very quickly, even if they're doing well, and there's a big area of research needed to understand who is at a higher risk for relapse of migraine off of preventative therapy.

Elizabeth DeStefano (06:10): Now does that observation of someone stopping a preventive — and even if they get a little bit worse than they were on the preventive, not getting as bad as they were before starting the preventive — does that hold true across classes of migraine preventives?

Dr. Robbins (06:27): That's a great question. So far, it seems to have done so. So, it's been demonstrated in medications like topiramate, like valproate — which we don't use as much anymore, or hardly at all. It's been shown in some of the newer calcitonin gene-related peptide or CGRP- targeting therapies. And in our experience, it seems to also be the case with botulinum toxin [Botox]. So, I think it seems to be consistent across different classes of treatments.

Dr. Robbins (06:57): And in some ways, that's frustrating because we thought that the newer CGRP-targeting treatments might be more disease-modifying, so to speak. And they still could be in some people. Just when you look at everyone on a whole, it still looks like people off of the treatment still get, on average, a little bit worse, but not as bad as they were before they started the treatment.

Elizabeth DeStefano (07:18): So, it's interesting that this topic itself brings to light this question about whether the preventives themselves are modifying the disease or suppressing its manifestations — its symptoms — and that there's a little work to be done there to really have a definitive answer on that.

Dr. Robbins (07:35): Yes, absolutely right. We need some type of what we would call a biomarker — something about someone's story, about their symptoms, maybe about their blood test or some genetic marker — that would suggest who is it more favorable to stop a preventative treatment [for] and who it should really be continued [for]. As it is now, the recommendations might be based on things like headache frequency.

Dr. Robbins (08:01): So, I think we generally presumably apply many people, and it's been written about, the indications for starting preventative treatment. If you just went by a coarse number, it might be four or more migraine days per month or two or more migraine days per month that are difficult to treat acutely. And if someone is on preventative therapy but is still above that threshold, you might say, "Well, migraine is still pretty active and probably preventative therapy should be continued."

Dr. Robbins (08:29): But if it really drops below to a very infrequent episodic pattern — I mean, those are the people who I really consider with every visit — should we wean or reduce or stop a preventative therapy?

Elizabeth DeStefano (08:40): How do you and your patient know when the time might be right? Are there clinical benchmarks or green lights that you look for that suggest a person is ready for this conversation of reducing or stopping a preventive?

Dr. Robbins (08:54): Well, I think at every visit we should discuss whether preventative therapy should be continued, maintained, adjusted, added to, or subtracted. I think really it should be part of the quality of care that we do for every patient. Now, I think there are certain numerical benchmarks that many people use that are similar to how someone is started on a preventative therapy.

Dr. Robbins (09:17): That could include if they have, say, four migraine days per month in general, which would be an indication to start preventative therapy. If they've reduced all the way down to that, that might be also a benchmark to reduce or stop preventative therapy.

Dr. Robbins (09:34): How responsive they are to acute medications would be another situation because we wouldn't want someone to stop their preventative therapy even if the attacks aren't as frequent as they are before, but they don't respond as well to rescue medications that are so important for them. And then there's bigger-picture items for people who might have chronic migraine.

Dr. Robbins (09:53): Chronic migraine is such a tough condition to define by having migraine so frequently — half of all days for at least three months in a row in any given year, and half of those days are more severe migraine days. There's some people who advocate to consider such a

preventative treatment change, or lowering or stopping, if they revert from a chronic to an episodic pattern.

Dr. Robbins (10:15): But there's so much nuance in that because there's an arbitrary number of — are you above or below 15 days per month? And if you revert from 18 days per month to 12 days per month, should you really stop preventative therapy? And in that case, I would probably say no. So, I still would think there should be a really significant improvement that is noted. And the other benchmarks I would look for, Elizabeth, would be life circumstances.

Dr. Robbins (10:39): So here's an example: I would see a patient who, say, is a 47-year-old woman with chronic migraine. She's doing really well on, say, a CGRP-targeting therapy but has noticed symptoms of perimenopause that are coming, which is very common, and perimenopause can be a big activator for migraine to be worse, at least in a temporary period of time that could be very extended. Or someone is going on a trip and traveling overseas or is having a big stressful life event coming up that could be good or it could be difficult.

Dr. Robbins (11:12): I think those would be circumstances where I definitely would hold tight on preventative therapy and not change them. So, there's a total customization of this type of strategy for how we handle maintaining or reducing preventative therapy, depending on life circumstances.

Elizabeth DeStefano (11:27): So, some of the things you're looking at are reduction in number of migraine-affected days; how responsive someone is to their acute or rescue medication; and then what's happening in their life — whether that's biological or otherwise — in terms of major life transitions or periods of time. Do you also consider factors like lifestyle habits or other coping strategies or support systems that are in place in considering taking a step like this?

Dr. Robbins (11:59): Yeah, and I think they're all interrelated in a way. But I think someone who cannot risk changing their migraine preventative therapy because it works; because they have busy, stressful lives; because the risk of having even a couple more breakthrough migraine attacks per month would be so tough on their quality of life — those would also be part of the conversation. I think that happens a lot.

Dr. Robbins (12:24): And even just in starting preventative therapy, that happens a lot where people who maybe have some high-risk work situation or family situation, even if their migraine attacks aren't terribly frequent, we're totally at liberty to discuss and start preventative therapy because having even intense but occasional migraine attacks might be worthy of prevention in such circumstances. So, the same goes on the other end when we're thinking about whether we should reduce or stop preventative therapy.

Elizabeth DeStefano (12:51): So, having discussed the whys and whens, let's talk now a little bit about the hows of stopping or reducing, the practical steps of doing this, and what that process can really actually look at. Can you walk us through how you would approach stopping something like Botox or tapering maybe an older traditional oral preventive like topiramate, a beta-blocker, or an SNRI [serotonin-norepinephrine reuptake inhibitor]?

Dr. Robbins (13:17): Yeah, these are great questions, and it totally depends on the treatment that's being used. Some treatments can just be stopped because they have very long half-lives. That includes botulinum toxin, that includes the CGRP-targeting monthly injectables or infusions because their half-lives are a month or so. And therefore when you stop it, you are weaning it slowly from someone's system automatically.

Dr. Robbins (13:42): And sometimes related to that, there's this whole situation about wearing off of those preventative therapies. If someone experiences a recurrence of migraine symptoms leading into when they're due for the next dose or the next injection series, then that might be a sign that the preventative therapy should just be continued.

Dr. Robbins (14:04): It's an area of a bit of controversy because in the clinical trials when they've extended people out to look at this wear-off phenomenon, it's not really seen. But in headache clinic studies and people's observations of what patients tell us in the clinic all the time, they super commonly report that these treatments wear off — which includes botulinum toxin and the monthly monoclonal antibodies or the quarterly infusion monoclonal antibody, like eptinezumab [Vyepti].

Dr. Robbins (14:33): So, I think if it's an injectable though and you want to stop it, you can probably just stop it because it's going to peter out on its own. If there is going to be an oral medication, I think you definitely lower it at a pace that's slower for how it was titrated or initiated to begin with. And this might involve some creativity in terms of cutting pills in half or using low doses or getting formulations where there's lower doses.

Dr. Robbins (15:00): I think in someone who you think you're really wanting to do it gingerly — you really want to do it — reduce it even much more slowly than when it was started.

Elizabeth DeStefano (15:10): And what are the specific risks of not taking that approach in reduction?

Dr. Robbins (15:17): Well, I think for most treatments it would just be a migraine relapse, so to speak. There are some treatments that must be weaned slowly. I think, for example, an older medicine like topiramate, it is an antiseizure medicine, so if someone was on a very high dose — even if they don't have a history of seizures or epilepsy — withdrawing it very suddenly might not be a good idea.

Dr. Robbins (15:39): The same for certain antidepressant medications, especially medications like SNRIs, such as venlafaxine or duloxetine, that may be used for migraine. They notoriously can have a withdrawal-type syndrome if you abruptly stop it or wean the medicine too quickly. So, I think those have a higher risk of withdrawal in addition to a migraine breakthrough if that situation lets us know that people still really do need that preventative therapy.

Elizabeth DeStefano (16:11): Can starting or increasing the role of nonpharmacological approaches play a part in the process of either weaning or stopping preventive treatments?

Dr. Robbins (16:22): Yes, I think that's a great question. I think we want people to be as prepped as possible to get off the preventative therapy, so they should have their acute treatments in hand. They should have coping strategies ready. Maybe we would introduce nutraceuticals — supplements that might have evidence for migraine prevention that people are willing to take because they're generally without too much safety risk at all.

Dr. Robbins (16:47): Using maybe devices that have good evidence for treating migraine or preventing migraine that might smooth the exit strategy for people who want to get off of such a preventative therapy. So, it kind of depends. I think some people, they just want to get off their preventative therapy and be on no prevention and nothing. And that's totally fine if the circumstances support that.

Dr. Robbins (17:08): But in others who you are a little bit worried about because they maybe have a baseline higher frequency even if they're doing much better relative to before, those are the people where we want to really optimize all of their strategies to make sure that this is the right time to come off of a preventative therapy.

Elizabeth DeStefano (17:23): So, it seems pretty safe to say that the number one concern probably for most people would be a fear of relapse if they were to pursue reducing or stopping a preventive. How do you approach counseling patients about that concern, that fear, that apprehension? And what is a good, kind of, safety net action plan for increased migraine frequency or severity if you do see those as this attempt to reduce or stop this pursuit?

Dr. Robbins (17:58): Yes, I think a couple of strategies. One is that migraine is so cyclical. So, I think, I often — if someone is going to come off of a preventative therapy or lower it — I think attributing a migraine relapse to that very circumstance might sometimes be false. And sometimes you have to really tell someone to stick it out a little bit longer to see if it's just, was there a certain trigger present or was [it] just the normal up and down? Because we're really looking at the long-term trends.

Dr. Robbins (18:25): I think a strategy to ramp back up to the preventative therapy where someone was should also be in place. So I don't typically discontinue a medication order from a pharmacy. I keep everything going until we're sure the patient is off in case they need to get their medication back or they have it on hand still to resume it. So I think we always have contingency plans like that. But I think often it does require people to understand about the longer term, the long game for this.

Dr. Robbins (18:50): And I think migraine is such a cyclical and erratic condition. Sometimes we might not wait long enough to stop a preventative therapy. And we really want to see how people do in at least a few weeks. I mean, I think if someone has a migraine attack, the day after you stop a preventative therapy and then the next day they're fine, they should keep stopping the therapy. But if they develop status migrainosus that lasts a week, that would be a different story.

Elizabeth DeStefano (19:17): Is it important to have a communication plan in place between you and the patient to monitor for that, to know what is an expected or acceptable response versus what isn't?

Dr. Robbins (19:33): Yes, I think all these things that we've discussed should be discussed at the patient visit or at whatever the stage of the communication is.

Dr. Robbins (19:40): So, I think, someone who you think might go into status migrainosus the day after you stop a preventative therapy, you're probably not going to stop that preventative therapy anyway — unless there was some more urgent health issue or someone had an unexpected pregnancy or some other circumstance like that that might mandate such a treatment plan.

Dr. Robbins (20:00): But yes, I think close communication is really important, setting the expectations right, understanding that there's comfort and contingency planning in case things get worse again, and also the understanding that you might just need to try again in the future — that sometimes it's not just one attempt to get off a preventative therapy. You may have to let things restabilize and then try again in the future.

Elizabeth DeStefano (20:22): You mentioned that probably all too often patients stay on medications without really pausing with their provider to talk about whether reducing or stopping is appropriate. Do you think that's probably more often at play than someone reducing or stopping prematurely?

Dr. Robbins (20:43): I think it's hard to say the numbers. I would say the treatment where that comes up often is with botulinum toxin. I think people start botulinum toxin. It's a great treatment. It works for the majority of people for chronic migraine. And then they stick with it every three months, kind of in the long run. And people do great. And sometimes we just don't know if we stop it, will they relapse again?

Dr. Robbins (21:02): And that wearing-off phenomenon could be one sign that we help to judge that. But I think the treatments that people kind of stick with in the long time where we're unsure if they really need it might be botulinum toxin more just because it's such a safe treatment. The patient doesn't have to — patients don't take a medicine. They come to the clinician for the treatment.

Dr. Robbins (21:25): And it generally doesn't have, aside from the procedure-related circumstances, side effects to a significant degree. So, I think a lot of it is because of convenience. And it's totally related to the safety of certain treatments that people might stick with them for longer, even if they're doing really great.

Dr. Robbins (21:44): But it just goes to show you that we need some type of marker or evidence or guideline to suggest how we should reappraise stopping any preventative therapy when people are doing really well.

Elizabeth DeStefano (21:57): So, let's talk about what might feel like the worst case scenario for someone who's approaching this stage, the idea of stopping a preventive and their migraine comes back and it progresses or reverts to chronic migraine. You talked about the fact that if someone is in that situation, the reappearance or increased severity isn't usually to the extent that it was prior to them taking the preventive.

Elizabeth DeStefano (22:22): But in that case, would that person simply restart the same medication, assuming they hadn't stopped for health reasons or because of pregnancy or planned pursuit of pregnancy? So, would they start the same medication? Is there a risk that restarting that medication would mean that one isn't as effective as moving to a different medication? How do you approach choices there?

Dr. Robbins (22:49): These are great questions, Elizabeth. In general, I would say yes. I would say typically if the previous preventative therapy was successful to at least a moderate degree, then you want to go with what might be potentially more of a sure thing and restarting what had proven to be helpful for that particular patient. But we often do have the discussions — should we use this opportunity to maybe use a different preventative therapy in case that prior one caused side effects or had some concern? So, it could change.

Dr. Robbins (23:15): But I would say in the majority of circumstances, we want to restore the benefit that existed before and we typically go back to the preventative therapy that they were on.

Elizabeth DeStefano (23:28): And would that hold true even if they were on an older, more traditional medication and hadn't yet tried one of the newer medications?

Dr. Robbins (23:37): Time could be of the essence for some of this type of circumstance. So, if someone has developed a severe migraine relapse, they're using acute medications all the time; they're thinking about going to the emergency department. That's really bad. I think you want to do whatever you can to get it under control quickly. And often that includes restarting the medication that they were on before that they hopefully still have on hand at home.

Dr. Robbins (24:02): But I think … if we think that there's a better preventative that they haven't had before and there's emerging evidence that some of the newer CGRP-targeting therapies are better than many of the older ones, which we've seen in a few studies now, then that might be a good opportunity to institute one of those as well.

Elizabeth DeStefano (24:19): So, for the person listening to this who is doing well on a preventive and is now thinking about this for the first time, what is the single most important piece of advice you can offer as they consider starting this conversation with their provider?

Dr. Robbins (24:35): I think I would suggest it should be a topic of conversation at every visit. Do you still need this preventative therapy? If it's one that's at a certain dose, is it time to reduce it? What's coming up in life that should help to dictate that decision so there could be a partnership in making such a decision together? I think it's something that should be discussed at every visit.

Dr. Robbins (24:55): In my notes, in my practice, in my electronic medical record, I have a template about every patient that aligns with the quality measures for how we treat people with migraine that are aligned from organizations like the American Headache Society and the American Academy of Neurology.

Dr. Robbins (25:12): And in the preventative treatment measure, in my plan, in the note — which patients now see all the notes that we write — it talks about what's their migraine frequency and the rationale for either continuing, proposing a discontinuation, or augmenting preventative therapy. So, I think it should pretty much come up at every encounter.

Elizabeth DeStefano (25:30): So for the person for whom you are considering reducing or stopping a medication — not necessarily because it has worked so well that their migraine frequency or severity has reduced, but because they fit into another category, either a health event or because they are planning on trying to become pregnant — how would the conversation and the steps towards removing that medication from their management go?

Dr. Robbins (25:59): Well, that's a great question and a very practical one that comes up all the time. So, I think pregnancy is a circumstance where this is really apparent. And what I would say is that, first, the best time is always to do it well in advance. I think just like any OB-GYN would say, preconception counseling is always the best for anyone who is thinking about pregnancy, about just in general what to expect, and also with coexisting medical conditions.

Dr. Robbins (26:26): The same goes with migraine and people who are on preventative therapy. So, I think, in general, the principle for a circumstance like pregnancy is that — thank goodness — most women who are pregnant do much better in pregnancy. And that's certainly true for women who have migraine without aura; perhaps to a lesser, clear extent for women who have migraine with aura; or people who have chronic migraine, where the prognosis in pregnancy might be a bit more murky.

Dr. Robbins (26:51): But on average, people do very well in pregnancy. So, I think, first of all, my goal is to reassure people that it's OK to stop a preventative therapy for safety reasons in advance of trying to conceive, and that pregnancy may be a time where migraine is going to get better, and pregnancy might be a better preventative therapy than any preventative therapy we have. And then certainly, in terms of the weaning or the stopping of a treatment, it depends on what the treatment is.

Dr. Robbins (27:17): Most oral medications have short half-lives in terms of how long they last in someone's system, so they typically can be discontinued within days or a week or two weeks, at the longest, of stopping medication before someone tries to conceive. The medications that last longer, like the CGRP-targeting monthly injectables or botulinum toxin, they have much longer half-lives.

Dr. Robbins (27:38): And the general recommendation has still been to let the CGRP-targeting monthly injection clear out of someone's system all the way for five or six months before trying to conceive. Although so far, all the pregnancy-registry datasets have not so far shown any signal of safety issues if people have done that sooner than that, but more data must be accumulated by everyone to prove that point.

Dr. Robbins (28:02): And then botulinum toxin also — it lasts for three months or 12 weeks — but there's increasing data that's shown that early exposures to botulinum toxin around the time of conception or first trimester may not really be associated with any adverse maternal or fetal outcomes at all. So I think we're probably in general less concerned about that particular treatment.

Dr. Robbins (28:26): And then the other part of this counseling that happens is that there are plenty of treatments that are safe in pregnancy for women with migraine.

Dr. Robbins (28:32): This includes some short-term preventative treatments, this includes some preventative treatments, it includes many acute treatments, it includes nonmedication therapies like devices, nerve blocks with anesthetics — all these things are generally quite safe in pregnancy and can be effective and could be good treatments to use when someone might feel to be more vulnerable off of the preventative therapy that had worked before trying to become pregnant. So, I think that would be my general strategy in that particular circumstance.

Elizabeth DeStefano (29:04): What key information should people be tracking in between their visits so they can most effectively have this conversation during every visit?

Dr. Robbins (29:15): I think it's some of the usual suspects — migraine frequency or headache frequency; acute medication use; for women in circumstances like perimenopause, relationship with that type of an internal trigger; and also just coming to the clinician with what's going on in life. And so there's just a more common-sense approach to what we should do with preventative therapy.

Dr. Robbins (29:39): There's a lot of inertia in this where we would just continue preventative therapies for people if they're doing well, and that's great. And thankfully, we haven't seen any long-term issues with most preventative therapies that are used.

Dr. Robbins (29:50): But some of the older medications certainly have them. For example, antiseizure medicines like topiramate, in theory, are associated with bone loss and vitamin D metabolism, and could put people at a higher risk of osteoporosis, for example. So, I mean, that

would be one medication if someone's on it for a long time where there could be long-term health consequences, and certainly that discussion should be had.

Elizabeth DeStefano (30:13): It's very clear that having these conversations regularly, routinely at each visit with those you care for is part of your practice. I think for a lot of us, this is not something that is visited during every appointment. Is there anything you could offer in terms of encouragement or practical suggestions for those listening who might feel it's — the onus is on them to introduce this regularly and how to approach that?

Dr. Robbins (30:42): Well, I think it can be hard, especially for people who have chronic migraine, where migraine has been so embedded into their life and quality of life — but people get better. We have better treatments now more than ever, and often it's the very long-term sustained trends that are important to note. And I think the longer the trend, the better the prognosis, I would say, in terms of chances of success of reducing or stopping a preventative therapy.

Dr. Robbins (31:10): And in some people, it's not possible, right? It's just they have really tough chronic migraine, and if we stop it, we know things are going to relapse in a tough way, and that's realistic. Thankfully, we have better treatments that are safe, and in the long run, they can be maintained without too many issues.

Dr. Robbins (31:25): But I think in general, it starts with the beginning. There should be optimism from when a preventative therapy is started — whether it's a primary care clinician, whether it's a neurologist or a headache specialist or whoever the clinician is — that this will not be forever. This is going to be for a period of time to get things under good control, and then we're going to consider stopping it or reducing it when the time is right.

Elizabeth DeStefano (31:47): So, to wrap up here — in terms of your experience, your expertise, and how you approach this — is tapering down and/or stopping preventive migraine medications for those who really seem to have changed, to improve to episodic migraine from chronic migraine, something you often do in your practice?

Dr. Robbins (32:11): I do. I do. I do think it's important to revisit that often, and it depends on all the factors that we've been discussing. But I think it's important to not commit people indefinitely to treatments that they may not need for such a long period of time.

Elizabeth DeStefano (32:28): Well, is there anything on this topic, Dr. Robbins, that we haven't covered that you'd like to leave those listening to this and considering this stage in their treatment with?

Dr. Robbins (32:41): Well, I think we're in an era of great preventative treatments for migraine, and I think it's great that so many people nowadays have been started on them. And I think the burden of migraine — I think as a whole in society — will diminish over time because of the great treatments, but that does not preclude the discussions about stopping those treatments that should not necessarily be indefinite.

Elizabeth DeStefano (33:05): Are there any resources on this topic you'd like to point listeners to — to explore further?

Dr. Robbins (33:11): I wish there were. In fact, it's a real gap in the literature for scientists, for clinicians. There's been articles written about it by different medical professional societies —

including the American Headache Society, the International Headache Society, the European Headache Federation — but no clear guideline or position about how to stop or reduce a preventative therapy over time in someone who's been on it. So, I think one of my goals in my career is to help get that together in some way.

Elizabeth DeStefano (33:43): Thank you for that and everything that you do really for all of us living with migraine. We really appreciate you, and diving into this topic. It's such an important milestone that so many people are in, as we've learned by our community's interest in this topic — which is cause for celebration in and of itself — and one that so many people are working towards and hoping for as they do figure out their journey and their trajectory towards migraine being less of a burden.

Elizabeth DeStefano (34:14): So, we really appreciate you walking us through some of the important things to think about in terms of the whys, whens, and hows to embrace it. So, thank you. And where can we learn a little bit more about you, Dr. Robbins, and the work that you do?

Dr. Robbins (34:31): Well, I'm out there in different platforms like LinkedIn and on my page at Weill Cornell where I work, and certainly through my work through organizations like the American Headache Society. So, I think those are good places to find out more.

Elizabeth DeStefano (34:47): Well, thank you so much, Dr. Robbins, for joining us yet again on the Migraine World Summit.

Dr. Robbins (34:53): Thank you, Elizabeth.