

SHOULD WE ADVISE PATIENTS TO TREAT EARLY? – NO

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On the face of it, the logical answer to this most often asked question seem to be 'YES'. But is this true in clinical practice?. For this debate I will be defending the view-point that- although treating migraine early is an attractive approach for achieving higher efficacy, unfortunately, thus far there is no convincing scientific evidence that early treatment affords improved efficacy. Let us now look at some of the evidence that favours this view point.

That triptan efficacy may be enhanced by treating the attack when the pain is mild was first suggested by Cady et. al. based on the Spectrum Study. And pathophysiological support for this was provided by the study in which Burstein and colleagues showed that the presence of allodynia may influence the response to triptans. Response to sumatriptan when given earlier in the limited 'window of opportunity' before allodynia develops is better than after allodynia sets in. But for the following reasons, all these conclusions are not justified and early intervention strategy is NOT the only way to enhance the effectiveness of anti- migraine therapy.

1. Most of the evidence for the efficacy of early triptan intervention in migraine is derived from retrospective analysis of data from trials not designed to evaluate the benefit of early intervention.
2. When comparing different treatments, the baseline characteristics of the study populations and other prognostic factors must be balanced. Studies comparing patients who treat mild and patients who treat severe headaches are actually comparing different study populations.
3. 'Treating Early' and 'Treating Mild' have been used incorrectly as interchangeable terms. This would be right only in patients with slowly progressing attacks but not in patients with rapidly progressing attacks. It is therefore important to include only one type of patients in a study and then compare early and late treatment.
4. The retrospective trials had defects in study design. Just comparing absolute response rates in different study designs without accounting for different placebo responses may be misleading.
5. Early intervention may have other disadvantages in clinical practice. When patients are told to treat every headache as soon as possible there is a danger of inadvertently encouraging medication overuse particularly in patients with frequent migraine.

Ideally, therefore, we should establish conclusions by properly designed prospective trials where we can regulate outcome measures, have a four arm parallel group design, test carefully for allodynia and do a proper statistical analysis. Although early intervention seems an attractive hypothesis, I would like to say in conclusion that it should not be the strategy in all. Only patients with disabling migraines, who have a high recurrence rate or in whom attacks are characterized by rapid progression of pain should be encouraged to treat their attacks as quickly as possible with triptans.