FOREWORD

Despite the high prevalence of migraine, the introduction of simple diagnostic tools and the availability of efficacious and well-tolerated therapeutic agents, migraine remains underdiagnosed and undertreated. When migraineurs were asked how satisfied they were with their usual acute treatment for migraine, only 29% indicated that they were very satisfied and 48% were somewhat satisfied.[1] A more recent survey of a clinic population reported that 66% of patients were very satisfied/satisfied with the initial medication that they took for their migraine attack, and 33% were dissatisfied/somewhat dissatisfied with the medications available.[2] Even though most patients were satisfied with their current medications, 88% reported that they would be willing to try a new antimigraine medication. As physicians, it is our responsibility to improve the management of migraine and patients' satisfaction with their treatment. For this reason, we convened a satellite symposium 'Optimizing Migraine Treatment Success' at the 9th European Federation of Neurological Societies congress held in Athens, Greece, on 17 September 2005. The articles in this supplement, based on the symposium presentations, provide data and strategies to assist physicians in providing their migraine patients with the best possible care.

Dr John Edmeads describes the problems we as physicians face in the management of migraine. In many countries, less that half of patients with migraine are currently consulting physicians, and a large number of those who had consulted in the past have lapsed from care. Migraine is often undertreated with non-specific agents when migraine-specific agents would be more appropriate, leaving a large number of patients dissatisfied with their therapy. To improve patient satisfaction, it is necessary to enhance patient–physician communication. Physicians must listen to their patients, validate their disorder and convey respect for their ability to persevere and be successful despite this condition. Physicians should educate their patients and encourage them to be more involved in their own care to help them better understand their disorder, identify and avoid migraine triggers, and improve their understanding of and compliance with drug therapy. Physicians can manage patient expectations and work as partners with them to guide patients in the best use of the most appropriate therapy.

Dr Christian Lucas discusses strategies that can be adopted to improve the acute treatment of migraine. First, physicians should differentiate from among antimigraine therapies using endpoints that are important to patients; for example, agents with high sustained pain-free rates (a difficult endpoint to achieve) will more likely result in higher patient satisfaction because they are associated with a rapid onset of pain freedom, the absence of recurrence and no use of rescue medication. Second, stratified care is the preferred treatment approach compared with step care. In step care, waiting for a patient to fail on a non-specific therapy before using a migraine-specific agent (e.g. a triptan) results in needless suffering and may cause migraineurs to lapse from care.

Third, it is important to match patients' particular needs with the attributes of individual triptans, as there have been shown to be clinical differences between these agents. Fourth, patients should be advised to treat their migraines when the pain is still mild and not wait for the development of moderate or severe pain. A large number of retrospective and prospective trials have shown that early treatment, before the development of central sensitization, results in higher rates of response to acute agents. If the above strategies are incorporated into a physician's practice, the likelihood of patients achieving satisfaction with their antimigraine therapy should be increased.

In the last article in this supplement, I describe the results of several recently completed clinical trials using almotriptan 12.5 mg. Whereas placebo and active-controlled registration trials have provided convincing data on the high levels of efficacy and tolerability of almotriptan, supporting its use as a first-line antimigraine agent, postmarketing trials have provided additional data on the use of this agent in real-world clinical settings. Postmarketing trials generally include larger numbers of more diverse patients and measure endpoints such as satisfaction and preference, which were not included in the registration trials. I will report the data from three randomized, double-blind trials, one comparing almotriptan with zolmitriptan, one comparing almotriptan with ergotamine plus caffeine and the third comparing almotriptan with placebo in patients who were poor responders to sumatriptan. I will also describe the data from three open-label postmarketing trials that investigated patient preference and satisfaction with their antimigraine therapies. These trials demonstrated high levels of efficacy, tolerability and satisfaction with almotriptan treatment in both triptan-naive patients and patients dissatisfied with their previous therapy. The findings from these new double-blind and open-label trials demonstrate that the high levels of efficacy and tolerability reported for almotriptan in the earlier clinical trial settings can be achieved in the real world.

By improving patient–physician communication, implementing treatment strategies such as stratified care and early intervention, and selecting acute agents such as almotriptan with high levels of both efficacy and tolerability, physicians can increase the likelihood of achieving successful and highly satisfactory outcomes for their migraine patients.

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