“Siege Migraines”: More Fiction Than Fact

by JAIME SANDERS

The Misconception of "Siege Migraines"

If you read the article where actress Ashley Judd describes her migraine as "siege migraines", you might be scratching your head as to what type of migraine that is. In an essay, Judd wrote in response to criticism she received on her appearance.

She stated, “What I know is that I have been sick with siege migraines for over a year, and that migraine affects one in four households in the US. It's the third most common disease in the world.”

Due to being prescribed steroids, her doctor limited exercise to mild walking. Enduring a four-month long migraine attack, Judd had unwanted weight gain. She took that moment to shine a light on her treatment, including receiving Botox every 12 weeks to manage her migraine.

If you were to search siege migraines, you are not going to find any formal diagnostic criteria. It is not on the ICHD-3 nor recognized by the American Migraine Foundation. The AMF suggested that what Judd experiences is chronic migraines. This is when a person has 15 headaches per month.

What Is a Chronic Migraine?

As mentioned above, a chronic migraine is classified as having 15 or more headache days per month, for more than three months, where on at least eight of those days the headache is symptomatic of a migraine. Each episode lasts four hours or more. The explanation for singling out chronic migraines from forms of episodic migraines is that in people with such severe or persistent headaches, it is impossible to distinguish the individual episodes of headaches.

In fact, the headache's characteristics can vary, not just from day to day, but even within the same day. To observe the natural history of headache, such patients are extremely hard to keep medication-free, attacks with and without aura are both counted in this situation, as are migraine-like and tension-like headaches. The most common cause of symptoms of chronic migraines are medication overuse, as described under 8.2 Medication-overuse headache in the ICHD-3.

About 50% of patients with chronic migraines revert to following drug withdrawal to episodic migraines. However, these patients are in a way misdiagnosed as having chronic migraines. Similarly, many patients who are reportedly overusing medication do not improve after drug withdrawal and the condition of medication-overuse headaches may be an inappropriate diagnosis for them. For these purposes, and because of the general rule to add all applicable conditions, patients should be labeled for both to meet criteria for chronic migraines and medication-overuse headaches.

In most cases, migraines will either return to an episodic type or stay chronic after drug withdrawal, and should therefore be re-diagnosed. In the latter case, the treatment of medication-overuse headaches may be terminated.

What Are the Causes and Triggers?

As with migraines, there are no known root causes of chronic migraines. However, there is a genetic component. If one or both of your parents have migraines, then there is a 50% to 75% chance that you will too. Knowing your family history is an important part in managing your migraine. If migraines run in your family:

- Ask family members specific questions about when their headaches began and what their symptoms and triggers are, and if the headaches have changed over time.
- Start a family headache diary to keep track of attacks and triggers.
- Create an environment of support so that everyone feels safe and understood.

How to Cope with Stress to Avoid Migraines

Trigger management is just as important with chronic migraines as it is with episodic migraines. Everyone has their own specific list of triggers that can bring on an attack without warning. These are common triggers that you can learn to manage and/or modify to lower the risk of an attack.

Stress

Reduce stress by maintaining a consistent sleep schedule, exercising, practicing relaxation, meditating and using biofeedback.

Weather Changes

We cannot control mother nature, so try to run errands when the weather is more comfortable. Stay indoors during inclement weather and heatwaves.

Caffeine and Alcohol

Avoid excessive use of caffeine and alcohol. Although a cup of coffee can aid in aborting a migraine attack, it can also be a trigger for some people. Know your limit when drinking alcohol. When you feel an attack coming on take your abortive right away.

Hormones

Women are three times more likely to experience migraines and around 75% have attacks around their menstrual cycle. Speaking with your headache specialist and/or gynecologist about the use of birth control as part of your treatment plan can help stabilize hormones and hopefully prevent future attacks.

Diet

Identifying food triggers can help you manage your diet and eliminate foods that bring on an attack.

Dehydration

Staying hydrated is especially important. Try to aim for half your body weight in ounces of water each day to avoid dehydration.

What Treatments Are Used?

Chronic migraines are treated much like episodic migraines, with both preventative and acute therapies. Common preventative treatments:

- Beta-blockers
- Anti-seizure medications

- Calcium channel blockers
- Antidepressants (tricyclics such as amitriptyline)

The FDA approved the use of Botox in 2010 for the prevention of chronic migraines. One treatment of Botox consists of 31 injections into specific points along the temples, forehead, bridge of the nose, back of the head, neck and upper back. These injections are administered once every 12 weeks.

Other newer treatments are the CGRP inhibitors, which are large molecule therapies injected once a month to prevent migraines. CGRP, or calcitonin gene-related peptide, is believed to cause migraines. It worsens pain and makes the headache last longer. The role of CGRP inhibitors is to block locations in and around the brain where CRGP has to work and bind to and prevent CGRP from functioning.

The available CGRP's on the market for the prevention of migraines:

- Erenumab (Aimovig)
- Fremanezumab (Ajovy)
- Galcanezumab (Emgality)
- Eptinezumab (Vyepti)

Acute therapies:

- Triptans
- NSAIDs
- Ergotamines
- Oral CGRPs (Ubrelvy, Reyvow)
- Gepants (Lasmitidan)