



LETTER TO THE EDITOR

Inequity of access to new migraine treatments[☆]**Inequidad de acceso a los nuevos tratamientos para la migraña**

Migraine affects 12% of the general population, is 3 times more frequent in women than in men, and represents the main cause of disability in patients between the ages of 16 and 49 years.^{1,2} It significantly reduces patients' quality of life; increases the risk of anxiety, depression, and suicide; and has a huge financial impact in society due to workplace absences and loss of productivity.^{3,4} In recent years, significant advances have been made in our understanding of the pathophysiology of migraine, which has led to the development of several monoclonal antibodies targeting the calcitonin gene-related peptide (CGRP-mAb) or its receptor: erenumab, galcanezumab, fremanezumab, and, more recently, eptinezumab.⁵ This is the first time that clinical neurologists have had a specific treatment at hand for migraine prevention. These CGRP-mAb may be prescribed to patients presenting more than 4 migraine attacks per month, according to the summary of product characteristics. However, considering that the cost of these new therapies is higher than that of the classical treatments, conditions have been established in Spain for the financing of these drugs, and are gathered in different therapeutic position statements,^{6–8} which limit their use to those patients with a high number of migraine days in whom at least 3 preventive drugs have previously failed; therefore, CGRP-mAb are fourth-line drugs. Thus, erenumab, fremanezumab, and galcanezumab are nationally funded in patients with 8 or more migraine days per month (high-frequency episodic migraine or chronic migraine) and treatment failure of 3 or more previous drugs used at sufficient doses for at least 3 months, with one of these drugs being botulinum toxin in the case of chronic migraine. This restricted use of CGRP-mAb is expected to change in the near future. In fact, considering that these drugs have shown better effectiveness, adherence, and tolerability than oral preventive treatments, the European Headache Federation has updated its treatment guidelines and recommends that CGRP-mAb be considered a first-line therapeutic option.⁹ The American Headache Foundation has adopted a similar position.¹⁰

The experience in Spain after more than 2 years of use of these drugs is very satisfactory, as they have been shown to be effective and especially well-tolerated.¹¹ Significant improvements have been observed in a high percentage of patients who presented frequent migraine attacks that limited their normal life and who had not found an effective treatment.¹¹ However, access to these treatments is complex and uneven. Inequities exist not only between different autonomous communities but also within individual regions, depending on the hospital treating the patient. As a consequence, many patients who need these new treatments are unfortunately not receiving them. This unequal access to CGRP-mAb is largely related to organisational and regulatory issues. From an organisational viewpoint, the waiting time to receive CGRP-mAb varies greatly according to the patient's place of residence. Patients must be diagnosed with migraine and subsequently, after failure of or intolerance to several classical treatments, will have access to antibodies. According to data from the Atlas of Migraine in Spain, mean time to diagnosis is above 6 years, and is highly variable between autonomous communities.⁴ Clearly, the organisation of care for migraine patients in Spain should not depend on the patient's place of residence. For this reason, all the specialties involved in the care of patients with migraine, including primary care, neurology, nursing, emergency, hospital pharmacy, and community pharmacy departments, together with the Spanish Association of Patients with Headache and Migraine have drafted the "White Paper on Migraine in Spain,"¹² a consensus document that includes proposals for 43 actions. One of the white paper's main conclusions is the need for the Spanish National Health System to adopt a strategic plan for a comprehensive, multidisciplinary, cross-sectional approach to migraine and other headache disorders to ensure that medical care is similar in all autonomous communities and to eliminate inequity. The second issue delaying access to the new treatments is related to the regional and local regulations in force. Each autonomous community and hospital may establish special conditions for financing, which are frequently different to those established in therapeutic position statements. In other words, there is a postcode lottery for access to a healthcare resource that, in many cases, is the only option to improve migraine.

In the Spanish Society of Neurology, we believe that it is necessary to correct the unequal access to new preventive drugs for migraine, and to adopt the European recommendations. Our patients should receive the treatments they need in accordance with their clinical situation, in a timely

manner and based on common criteria for the whole country, which should not depend on their place of residence. Our task is to help patients to reduce their disability and improve their quality of life, while reducing the costs associated with the workplace absences and loss of productivity caused by migraine.

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