Retreatment After Discontinuation of Anti-Calcitonin Gene-Related Peptide Monoclonal Antibodies in Migraine: Are There Any Predictors? Insights from a Real-World Cohort

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1 INTRODUCTION

Anti-CGRP monoclonal antibodies are effective in preventing migraine.
It is still unclear what factors predict the need for retreatment after planned withdrawal in well-controlled patients.

2 OBJECTIVE

To assess whether treatment duration with monoclonal antibodies targeting calcitonin gene-related peptide (CGRP), or specific demographic and clinical factors, are associated with the likelihood of retreatment after discontinuation in patients with migraine.

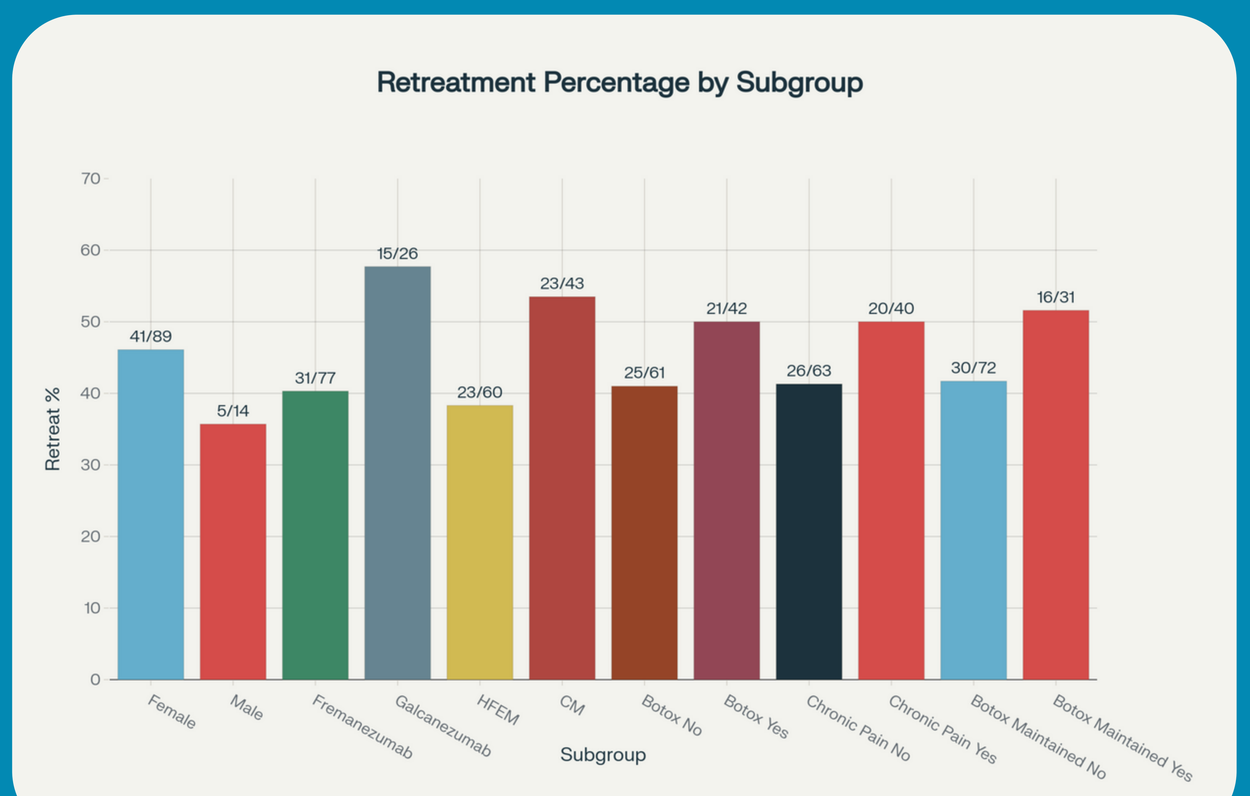
3 METHODS

Retrospective observational cohort study at a tertiary Headache Unit.

- We included patients with high-frequency episodic migraine (HFEM) or chronic migraine (CM) treated with anti-CGRP monoclonal antibody treatment (MABT) for ≥12 months, who discontinued due to a sustained good response, defined as ≥50% reduction in baseline monthly headache days (MHD) or ≤4 MHD.
- Data collected included age, sex, MHD at discontinuation, treatment duration, use of concomitant botulinum toxin, and other chronic pain conditions.
- Follow-up included MHD and HIT-6 scores every 3 months.
- Patients provided informed consent; study approved by local Ethics Committee (HCB/2021/1327).
- Variables associated with MABT reinitiation were analyzed using multivariate logistic regression (SPSS v20).

4 RESULTS

We included 103 patients (mean age 49.0±13.7 years; 86.4% female); 60 had HFEM and 43 CM. They received fremanezumab (n=77) or galcanezumab (n=26) for a median of 25.9 months (IQR 15.6–39.7).
Concomitant botulinum toxin was used in 40.8%.
MABT was reinitiated in 46 patients (44.7%) after a median of 91 days (IQR 67.3–126.2).
No clinical or demographic variable was significantly associated with reinitiation.



5 CONCLUSION

In this real-world cohort, nearly half of the patients who discontinued anti-CGRP monoclonal antibodies after a sustained good response eventually required retreatment.
No clinical or demographic predictors were identified, supporting individualized decisions and close follow-up.
Recent high-quality studies and reviews, including multicenter prospective cohorts and legally mandated withdrawal trials, indicate that consistent clinical or demographic predictors have not yet been identified.

REFERENCES

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