Letters to the Editor

More Options to Treat Migraine

To the Editor: Family physicians are at the forefront of diagnosing and treating migraine. The article by Moreland, et al., provides a helpful overview of migraine attack prevention but requires important clarifications.[1] The article states that migraine has a prevalence of 1%; however, the estimated prevalence of migraine in adults is in fact 12% to 14% (18% in women and 6% in men), translating to 40 million people in the United States and more than 1 billion globally.[2,3] This places migraine as the largest cause of disability before 50 years of age.[3]

The authors state that behavior therapies "are not recommended for migraine prophylaxis due to a lack of high-quality supporting evidence." However, behavior therapies are evidence based, included in the American Headache Society treatment consensus statement, and are recommended globally for migraine prevention.[4] Additionally, there are six (not three) neuromodulation devices cleared by the US Food and Drug Administration for acute and/or preventive treatment of migraine. Both neuromodulation and behavior therapies can be used alone or in polytherapy, can reduce frequency of attacks and burden, and are valuable when treatment options are limited, such as in children and pregnant women.[4-6]

We encourage readers to familiarize themselves with the range of effective pharmacologic and nonpharmacologic preventive therapies recommended in the American Headache Society consensus statements and forthcoming American Academy of Neurology migraine prevention guidelines.[4,7,8]

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In Reply: Thank you for your thoughtful letter. We appreciate the correction of the prevalence of migraine in the United States, which is 11% to 14%, whereas the prevalence of chronic migraine is 1%.[1] This highlights the importance of prevention.

Although current clinical practice guidelines conclude there is not enough evidence to recommend behavior therapies, consensus statements and expert opinions often recommend them because they are generally well tolerated, easy to implement, and have growing evidence of benefit. For instance, the 2021 consensus statement published by the American Headache Society encourages clinicians to recommend behavior therapies for select patients. However, it concludes that no evidence has emerged since the last consensus statement that is strong enough to change current migraine prevention guidelines.[2] The European guidance referenced in this letter is a review article that also encourages clinicians to recommend behavior therapies but is not a formal clinical practice guideline.[3] Similar to the use of supplements, we encourage physicians to offer patients resources on behavior therapies while being aware that there are no formal guideline recommendations due to the lack of high-quality evidence. We look forward to possible changes to the American Academy of Neurology guidelines, currently under development.

Of the six neuromodulation devices approved by the US Food and Drug Administration, only five have clearance for prophylactic treatment of migraines (one device is only approved for acute treatment, which was not the focus of the article). Additionally, only two are approved for use in children as young as 12 years, and only one is approved for use in children as young as 8 years.[4] Neuromodulation devices appear to be a promising treatment option for use in pregnancy; however,

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the safety evidence is limited for the three devices evaluated in this population.[5] We encourage physicians to inform their patients of pregnancy registries that are available for some of the devices.

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Buprenorphine-Naloxone Safe in Pregnancy

To the Editor: A recent article on the use of buprenorphine for treatment of opioid use disorder (OUD) thoughtfully reviews common questions that may arise from the primary care clinician's perspective.[1] In reviewing dosing regimens for buprenorphine, the author comments that buprenorphine monoproducts are primarily intended for use in pregnancy because the naloxone present in combination buprenorphine-naloxone products is not approved for use in pregnancy.

Although this was previously accepted practice, subsequent systematic reviews and meta-analyses demonstrate the safety and effectiveness of buprenorphine-naloxone in pregnancy.[2,3] No significant differences in gestational age at delivery, birth parameters, or prevalence of congenital anomalies were demonstrated in patients receiving combination therapy vs monoproducts.[3] Recent comparative evidence even favors the use of buprenorphine-naloxone over buprenorphine alone, given its lower risk of neonatal opioid withdrawal syndrome, neonatal intensive care unit admission, and small for gestational age diagnosis.[4] These data affirm that both transmucosal products are reasonable choices in pregnancy.

Patients who are stable on buprenorphine-naloxone at the time of pregnancy should be counseled that it is safe to remain on this treatment without disruption. Patients initiating medications for OUD during pregnancy who prefer buprenorphine-naloxone should be affirmed in this choice. One study in nonpregnant young adults found that receipt of a medication for OUD that is congruent with patient preference may be associated with reduced opioid use and increased treatment adherence.[5] This evidence further supports the addiction medicine and harm reduction principle of meeting patients where they are at.

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In Reply: I thank the writers for sharing this promising data on the safety of buprenorphine-naloxone in pregnancy, and the possibility of reducing the risk of neonatal abstinence syndrome (NAS).

The meta-analyses each reviewed the same limited collection of small retrospective studies.[1,2] One included five studies for a total of 1,875 pregnancies, and the other included seven studies for 302 pregnancies. Combining data from small retrospective studies allows for very limited confidence in results. The subsequent observational study with 5,385 total pregnancies with or without buprenorphine-naloxone exposure reported an overall rate of all major malformations of 5.2%.[3] Although none of the rates for specific organ malformations were significantly different, they had fairly wide CIs.

For NAS, the first meta-analysis reported a rate of 37.4% with combination products vs 55.8% with buprenorphine only.[1] The number needed to treat with buprenorphine-naloxone to prevent 1 case of NAS is 6, making it a reasonable low-risk treatment to consider for pregnant patients when discussing their priorities and preferences. Some patients may value maintaining their current treatment or reducing the risk of NAS, whereas others may prioritize minimizing prenatal exposure to any unnecessary medications. An informed consent discussion should include the limitations of the available data, and the clinician should qualify their recommendations accordingly.

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Technique for Foreign Body Removal From the External Ear Canal

To the Editor: The article on management of foreign bodies in the ear, nose, and throat did not mention an additional technique I have used for more than 30 years that was first published almost 5 decades ago.[1] Readers of a certain age may remember my description in *AFP*'s Diary From a Week in Practice in 1998[2]:

> While doing research for a presentation on removing foreign bodies from the ear and nose in children, I came across an old article in the May/June 1977 issue of the *Annals of Otology, Rhinology and Laryngology* (p. 369) that described a "new" technique, using dental impression material for removing nonoccluding foreign bodies from the external ear canal. A semifluid dental impression material is injected into the external auditory canal, then removed after curing, with the foreign body attached. The technique was described as "a more pleasant experience," for the patient and the doctor. [I] discussed the technique with a local dentist … [and] we waited for a good candidate. Today, a six-year-old came with left ear discomfort. A small bead was seen about halfway into the external auditory canal. The eardrum was intact. … The child was cooperative while [I] slowly filled the ear canal with the substance and some was placed externally to create a "handle" to pull out the core after curing. After 15 minutes, the patient was allowed to pull out the "core." Out it came, impression material and bead. It was painless, easy, and fun! This technique should not be used with a tympanostomy tube in place.

This 1977 study reported a success rate of 92% (23 of 25 cases) in patients who had been referred from the emergency department.[3]

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Editor's Note: This letter was sent to the author of "Foreign Bodies in the Ear, Nose, and Throat," who declined to reply.

Correction

Inconsistent definitions of prematurity based on gestational age. "Outpatient Care of the Premature Infant" (August 2025, p. 153) defined subcategories of preterm birth using inconsistent terminology and time frames in the article text and Table 1. The online version of the article has been corrected. ■