Prophylaxis a Must for Cluster Headache Patients

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LAS VEGAS — Every cluster headache patient needs to be on a prophylactic drug, Todd D. Rozen, M.D., said at a symposium sponsored by the American Headache Society.

"I tell them, 'I'm not happy, and you shouldn't be happy, until you're cluster free on prevention,' " noted Dr. Rozen, who is with the Michigan Head-Pain and Neurological Institute in Ann Arbor.

There are two types of prophylaxis for cluster headache: transitional treatments, which are intended to prevent cluster headaches from occurring for a short period of time (typically 7-14 days), and maintenance preventive treatments, which are designed to keep a patient cluster free while in a cluster cycle.

Transitional treatments must kick in quickly. They're used for 10-14 days, after which they're tapered down as the maintenance preventives are tapered up to a therapeutic dose. The transitional drug and maintenance preventive drug are typically started at the same time, Dr. Rozen said.

Corticosteroids are the most commonly used transitional treatment. Start prednisone at a dosage of 60-80 mg/day, tapering down over a period of 10-12 days, he said.

Naratriptan can be used at a dosage of 2.5 mg b.i.d., but monitor the patient for rebound headaches. Ergotamine, at a dosage of 2 mg at bedtime or b.i.d., also appears useful.

Dihydroergotamine can be given by daily intramuscular injections over a period of 1-2 weeks, or by an intravenous infusion for 3 days.

For reasons that are unclear, greater occipital nerve blocks seem to work well, giving some patients up to 13 days free of cluster headaches, even when their pain (like that of most cluster patients) is not located in the occipital area. The mechanism of action may involve decreasing afferent impulses to the spinal trigeminal nuclear complex.

For long-term prevention, a number of drugs work well, but many patients will need to be on combination therapy, taking two, three, or even four drugs to fully prevent recurrences.

"Melatonin is really my first-line choice because it is easy to get over the counter and there are no side effects," Dr. Rozen said. "[For] a small percentage of cluster patients, the night I give them melatonin is the last time they're going to have a cluster." The typical dosage is 9 mg at bedtime, although some patients have required higher doses.

Verapamil is the best cluster preventive currently available, Dr. Rozen said. He recommended moving the dosage up quickly, since some patients will need up to 1 g/day. ECGs must be performed at every dosage above 480 mg to monitor for heart block. Lithium carbonate, 300 mg t.i.d., appears to be well tolerated in cluster headache.

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Valproic acid, when pushed up to a dosage of 3,000 mg at bedtime, is sometimes effective.

Some small, uncontrolled studies suggest that topiramate may be effective for preventing clusters. When trying topiramate, increase the dosage in 25-mg increments every 4-5 days until the patient is taking 75-100 mg/day. When patients do respond to topiramate, it's usually in a short period, 1-2 weeks after starting the agent, he said.

Other preventive treatments that may be effective are transdermal clonidine, tizanidine, indomethacin, nasal capsaicin, gabapentin, baclofen, and histamine desensitization.

For some patients, steroids seem to be the only thing that works, Dr. Rozen noted, and of course patients shouldn't take corticosteroids chronically. He has had success in a single patient with mycophenolate mofetil (CellCept), the steroid-sparing immunosuppressant.

Dr. Rozen acknowledged being a member of the advisory board of Ortho-McNeil Pharmaceuticals Inc., whose products include topiramate (Topamax). ■

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