

Prophylaxis a Must for Cluster Headache Patients

Transitional treatments must kick in quickly; corticosteroids are the therapy most commonly used.

BY ROBERT FINN
San Francisco Bureau

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,'" said Dr. Rozen of the Michigan Head-Pain and Neurological Institute, 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 main-

tenance 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 for 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 mecha-

nism 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 tapering 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.

Valproic acid, 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 reported that 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). ■

History, Physical Critical in Secondary Headache Work-Up

LAS VEGAS — Even in a neurologist's office, every headache patient merits a general history and a physical examination, which may be the best tools with which to differentiate secondary from primary headaches, John G. Edmeads, M.D., said at a symposium sponsored by the American Headache Society.

"The headache never walks alone" when it is secondary to a general medical condition, said Dr. Edmeads of Sunnybrook Medical Centre, Toronto.

"There's always something on history or physical to give you a clue that there's a general medical disease going on. And once you have this clue you can diagnose them through a focused work-up that won't cost an arm and a leg," he said.

Dr. Edmeads offered the following suggestions:

► Neurologists can't assume that patients have had a thorough evaluation before reaching their offices. Dr. Edmeads said that he has had patients ask about the blood pressure cuff as if they had never seen one before.

► Be suspicious if the patient's signs and symptoms don't clearly meet International Headache Society criteria for primary headache. Any patient whose headache doesn't meet the society's criteria deserves additional investigation.

► If it's not clearly migraine or tension-type headache, look for

evidence of central nervous system involvement, either in the brain or its coverings. If there's any indication of CNS involvement, the next step includes neuroimaging and possibly examination of the patient's cerebrospinal fluid.

► If there are no signs or symptoms of CNS involvement, then conduct a general medical screen. This should include a CBC; an erythrocyte sedimentation rate; electrolytes, including calcium and phosphate; BUN and creatinine; liver enzymes and bilirubin; thyroid function studies, including TSH, T3, and T4; and a chest x-ray. Answers will come back within a day or two and will cost less than a couple of hundred dollars, Dr. Edmeads said.

► If those studies are negative, consider serum protein electrophoresis and arterial blood gases. In winter, consider carbon monoxide poisoning and test for carboxyhemoglobin. Carbon monoxide poisoning often results from poorly maintained heaters and will often present as daily, diffuse, nocturnal headaches that clear up in the morning when patients get out into the fresh air.

► If all results are still negative, but you still have a strong suspicion that the headache is the result of a general medical condition, consider a consultation with a general internist.

—Robert Finn

Comorbid Conditions Can Guide Migraine Prophylaxis

Drug	Efficacy*	Side Effects**	Relative Contraindications	Relative Indications
Antiepileptics				
Divalproex	4+	2+	Liver disease, bleeding disorders	Mania, epilepsy, anxiety disorders
Gabapentin	2+	2+		Epilepsy, possibly mania
Topiramate	4+	2+	Kidney stones	Epilepsy, obesity, possibly mania
Antidepressants				
Tricyclic antidepressants	4+	2+	Mania, urinary retention, heart block	Depression, other pain disorders, anxiety disorders, insomnia
Selective serotonin reuptake inhibitors	2+	1+	Mania	Depression, obsessive-compulsive disorder
Monoamine oxidase inhibitors	3+	4+	Unreliable patient	Refractory depression
β-Blockers				
	4+	2+	Asthma, depression, heart failure, Raynaud's disease, diabetes	Hypertension, angina
Calcium Channel Blockers				
Verapamil	2+	1+	Constipation, hypotension	Migraine with aura, hypertension, angina, asthma
NSAIDs				
Naproxen	2+	2+	gastritis	Ulcer disease, arthritis, other pain disorders
Others				
Riboflavin	2+	1+		Preference
CoQ10	2+	1+		for
Feverfew	2+	2+		natural
Botox	2+	1+		products

*efficacy scale: 1+ = low, 4+ = high.

**side effects scale: 1+ = mild, 4+ = serious.

Source: Stephen D. Silberstein, M.D., speaking at a symposium sponsored by the American Headache Society in Las Vegas, who acknowledged financial relationships with a large number of pharmaceutical companies with products for migraine