Treatment of Cluster Headache

**Acute**

**Medication**: Due to the rapid onset of pain, the most efficacious abortive agents are those that involve parenteral or nasal administration. Subcutaneous sumatriptan 6mg is the drug of choice with a rapid effect and high response rate. Unlike migraine, it can be prescribed at a frequency of twice daily, on a long-term basis if necessary without risk of tachyphylaxis or rebound. Most surgeries have been supplied with a placebo device for patient demonstration. There is placebo-controlled evidence for the use of zolmitriptan 5mg by nasal spray, and it is effective for many patients who don’t wish to inject.

**Oxygen**: Inhalation of 100% oxygen, at 10-12L/min, is rapidly effective in relieving pain in the majority of sufferers . It should be inhaled continuously for 15-20 minutes via a non-rebreathing facial mask. This is arranged by the headache clinic and the appropriate form (SHOOF)has been sent to the supplier. Please see the enclosed patient oxygen protocol form.

**Prevention**

**Short term**: Patients who have short, infrequent cluster periods can benefit from short-term prevention with Corticosteroids. This can also be used when initiating long term prophylaxis. The clinic protocol is prednisolone 60 mg for 7 days and then reduce by 10 mg every two days.

**Long term**: Patients with long bouts of episodic cluster headache or chronic cluster headache will require longer-term preventive treatment. Verapamil is the preventive drug of choice but higher doses than those used in cardiological indications are needed, commonly in the range 240 – 960mgs daily in divided doses. At higher doses there is a risk of heart block. The starting dose is 120 mg twice a day titrated up by 120 mg every two weeks. An ECG is required before starting treatment and after every dose increase.