

key points

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Cluster headache is a strictly unilateral headache that

occurs in association with cranial autonomic features. The male:female ratio is 3.5-7:1. Although it can begin at any age, the most common age of onset is in the third or fourth decade of life. The diagnosis is purely clinical and it is therefore crucial to take a good history looking for its distinctive features.

Although cluster attacks are unilateral, they may

alternate sides. Pain is excruciating and located mainly around the orbital and temporal regions though any part of the head may be affected. Attacks have an abrupt onset and offset and usually last around 45-90 minutes but can range from 15 minutes to three hours. Attack frequency generally varies from one every other day to three a day, although the International Headache Society criteria state there may be up to eight attacks a day. The key feature of cluster headache is the presence of at least one cranial autonomic symptom during an attack.

Alcohol, physical exertion, warm environments, sleep

and the smell of volatile substances can all trigger acute attacks. The majority (80-90%) of patients will have episodic cluster headache with recurrent bouts separated by remission periods of more than a month. The other 10-20% have chronic cluster headache and no significant remission periods over the course of a year.

Diagnosis is purely clinical and cannot be made on imaging.

However, the NICE guideline on headache recommends that the need for neuroimaging in patients with a first bout of cluster headache is discussed with a specialist. If imaging is considered necessary then an MRI scan of the brain is the most appropriate form. The main differential diagnoses to consider are secondary causes (e.g. vascular or neoplastic lesions), paroxysmal hemicrania and most commonly migraine. The clinical features that are most useful in distinguishing cluster headache from migraine include: relatively short duration of attack; rapid onset and offset of attacks; clear circadian periodicity; rapid precipitation with alcohol; agitation during an attack; and clustering of attacks with intervening remission periods.

Specialist advice should be sought at first presentation

for confirmation of diagnosis, development of a plan for managing current and future cluster bouts and where first-line treatments fail. Subcutaneous sumatriptan or nasal triptans should be offered to patients for the acute treatment of attacks. Inhalation of 100% oxygen at a rate of at least 12L/min given through a non-rebreathing mask and reservoir bag is rapidly effective in relieving pain in most sufferers. Corticosteroids are highly effective as preventive agents and act rapidly but caution should be taken in their use because of potential side effects, and no more than three courses should be given in a year. Verapamil is the first-line preventive treatment and should be considered in all patients where appropriate.