

Expert Opinion

Is It Migraine or Cluster?

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A headache with a cluster pattern but without autonomic features is difficult to classify.

CLINICAL HISTORY

This 27-year-old woman has had similar recurring headaches since aged 12. She reports a severe, right retro-orbital and temporal pressure associated with nausea and vomiting but no aura, light or noise sensitivity, ptosis, nasal congestion, tearing, or eye redness. The headaches almost always awaken her about 3 to 4 AM and last 1 to 3 hours. During the headache, she lies quietly in bed. Over the years, the headaches typically begin during her menses and recur once daily, occasionally twice, for about 3 weeks. The headaches then go away, but recur about 18 months later. Midrin and over-the-counter medications have not helped. Neurological examination is normal. I gave her sumatriptan nasal spray, 20 mg, which relieved the headache within 15 minutes.

Questions.—What is the diagnosis? Could this be cluster-migraine? Would preventative treatment be of benefit?

EXPERT COMMENTARY

The characteristics of this woman's headaches have features of migraine (unilaterally, severe intensity, associated nausea and vomiting) and some fea-

tures of cluster headache (retro-orbital pain locked to one side of relatively short duration occurring in clusters). The preference for rest during the attack and aggravation by menstruation supports the diagnosis of migraine, and the nocturnal occurrence during the cluster periods supports the diagnosis of cluster headache. The headache characteristics barely fulfill the major criteria of migraine without aura of the International Headache Society (IHS), but there are not enough features of cluster headache to meet IHS criteria for that diagnosis.¹ Features favoring cluster headache, such as the retro-orbital site locked to one side and nocturnal occurrence, are often reported by migraineurs, and even the cyclic occurrence of migraine has been reported.² Nevertheless, this case has enough features of cluster headache to warrant the label of migraine-cluster headache syndrome.³

However, when dealing with symptoms that are not typical of one of the primary headaches, further evaluation by an imaging study is warranted. Magnetic resonance angiography, for example, might reveal a vascular malformation underlying the consistently right-sided headache.

Treatment of the acute attacks in this case is similar to that for migraine or cluster headache. Sumatriptan subcutaneously or by nasal spray is most appropriate because of the sudden onset awakening the patient from sleep with nausea and vomiting.⁴ For prophylaxis, each cluster period should be treated as one would treat typical cluster headache, with a brief course of prednisone plus verapamil during the weeks of the cluster period.⁵ Alternatively, I would favor divalproex over propranolol because the former may be effective for

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both migraine and cluster headache.⁶ Similarly, in view of the short cluster period, methysergide would be appropriate.

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