Cluster Headaches - a brief summary of the NICE guidelines for GPs

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What do I need to know about cluster headaches in four bullet points?

- Cluster headache is a rare but severe type of headache.
- GPs should refer suspected cluster headaches to neurology (referrals should clearly indicate the presence of the characteristic features of cluster headaches).
- Cluster headache is distinguishable from migraine in that cluster headaches are usually abrupt, of shorter duration (15 minutes to 3 hours), more severe (causing the patient to pace around) and tend to occur at the same time of the year. They are associated with autonomic features (e.g. eye redness and/or tearing, nasal congestion and/or rhinorrhoea).
- First line treatment for acute attacks is triptans and oxygen therapy.

What does the NICE guideline say about cluster headaches?

Background and Epidemiology

- Cluster headache is the most common subtype of a group of rare headache disorders called trigeminal autonomic cepalahgias (TAC).
- Their pooled lifetime prevalence is 124 per 100,000 (12.4 patients per GP practice with 10,000 registered patients).
- The peak age of onset is 20-40 years old.
- They are more common in men than women (odds = 3:1).

Clinical Features

- Cluster headaches are severe and unilateral.
- Cluster headaches are characterised by prominent autonomic features.
- Cluster headaches usually occur in ‘clusters’ (hence the name) which last for between 2 weeks and 3 months with a period of remission between clusters.
- Attacks last between 15 minutes to 3 hours.
- Cluster headaches have a significant effect on quality of life (QOL). Affected people often live in fear of the headaches, often struggle to maintain employment, and are depressed, anxious and sometime suicidal.
- Precise ICHD-3 diagnostic criteria for cluster headache are listed in the box below.

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At least five attacks that fulfil the following criteria:

- Severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15–180 minutes (when untreated)
- Either or both of the following:
  - At least one of the following, ipsilateral to the headache: conjunctival injection and/or lacrimation; nasal congestion and/or rhinorrhoea; eyelid oedema; forehead and facial sweating; or miosis and/or ptosis
  - A sense of restlessness or agitation
- Attacks have a frequency between one every other day and eight per day for more than half of the time when the disorder is active (during cluster bouts)
- Not better accounted for by another ICHD-3 diagnosis

Episodic cluster headache

- Attacks fulfilling criteria for cluster headache and occurring in cluster bout periods
- At least two cluster-bout periods lasting from 7 days to 1 year (when untreated) and separated by pain-free remission (out-of-bout) periods of at least 3 months

Chronic cluster headache

- Attacks fulfilling criteria for cluster headache
- Occurring without a remission period, or with remissions lasting <3 months, for at least 1 year

Referral

- GPs should refer to Neurology at STH for diagnosis if cluster headache is suspected.

Management

- Most post-diagnosis management of cluster headaches should be provided in primary care.
- First line treatment for acute attacks is triptans and/or oxygen therapy.
- Prophylactic treatment with verapamil should be established and stabilised by neurology (after which GPs can continue to prescribe).

Oxygen Therapy

- Oxygen can be prescribed via NHS England's home oxygen order form (HOOF).

References

1. https://cks.nice.org.uk/topics/headache-cluster/
2. May, A., Schwedt, T., Magis, D. *et al.* Cluster headache. *Nat Rev Dis Primers* 4, 18006 (2018). https://doi.org/10.1038/nrdp.2018.6
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