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ACUTE AND PREVENTIVE PHARMACOLOGIC TREATMENT OF CLUSTER HEADACHE

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To the Editor

We read the recent review by Francis et al.,¹ who analyzed the quality and levels of evidence of clinical research trials for cluster headache (CH) treatment. However, their hierarchy of treatments does not adequately represent the manner in which headache specialists currently treat patients with CH.

The preventive therapies listed (table 4¹) do not reflect our first choices for treatment. Although sodium valproate is “not advised,” we consider it a second-line preventive measure. Civamide (a Z isomer of capsaicin) is rated as class I, level B for CH prevention, yet it is not available in any country. Verapamil (class II, level C) is our first choice for prevention of CH and prednisone (class III, level U) is our favorite short-term preventive along with verapamil, which is effective and widely used.

The authors state: “There is insufficient evidence to advise the use of dihydroergotamine, ergotamine, somatostatin, and prednisone for the acute treatment of CH (level U).” Although these would not be our first preference, dihydroergotamine, ergotamine, and prednisone work well as abortives in CH.

This disconnect between levels of evidence for published clinical research trials and appropriate treatments for CH stresses the importance of understanding the definition and intent of evidence-based medicine (EBM) by Sackett et al.² EBM is “the judicious use of the best current evidence in making decisions about the care of the individual patient. The

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practice of EBM means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”²

Francis et al.¹ note that “verapamil is generally considered to be the mainstay of preventive therapy” for CH, and that while both verapamil and lithium “received [level] C advice, they are used much more routinely in clinical practice than [capsaicin],” which received a level B rating. The recommendations for preventive therapy of CH from meta-analysis greatly differ from the way headache specialists actually treat their patients.^{3–5} The findings from this study partially appear to reflect the age and generic status of many of the pharmacologic agents used for CH treatment.

Increased scientific rigor is necessary for future clinical studies in CH. Until then, clinical judgment and experience should be relied upon for optimal treatment.²

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