INFORMATION SHEETS FOR CLINICIANS
Headache Management System for Adults

Paroxysmal Hemicrania

Epidemiology

Population-based data on the prevalence of paroxysmal hemicrania is sparse and has been cited as 0.05% in the 18-65-year age group.

Total published cases remain less than 200.

There may be a slight female preponderance with ratios ranging between 1.1 to 2.36.

Mean age of onset is between the 4thand 5th decades.

Clinical Features

The pain is strictly unilateral with associated ipsilateral autonomic features (http://www.ichd-3.org).

Attack duration ranges between 2-30 minutes and frequency of attacks is reported up to 50 a day. The mean lies between seven and 13 attacks per day.

The disorder has an absolute response to indomethacin.

The attacks are shorter and more frequent than in cluster headaches and longer and less frequent than in SUNCT/SUNA. The typical circadian characteristics seen in cluster headache are less prominent in paroxysmal hemicrania. All attacks are spontaneous unlike SUNCT/SUNA, in which attacks are often triggered immediately by various sensory stimuli. The key distinction is the clear therapeutic response to Indomethacin.

Management

There are no RCTs for preventive treatment in paroxysmal hemicranias.

Acute treatment

The attacks of paroxysmal hemicrania are usually too short to respond to any oral acute treatment. Open label observation suggests that sumatriptan 6mg subcutaneous injection and high flow oxygen are generally not effective.

Preventive treatment

By definition paroxysmal hemicrania is an indomethacin-responsive disorder.

The effective dose range is between 25-300mg daily dose.

Although most patients show a rapid response to indomethacin, some patients can take up to a week to demonstrate a response to an effective dose. Based upon this BASH recommends indomethacin 25mg PO TDS for 7 days, 50mg TDS 7 days, up to 75mg TDS. We recognise and emphasise the higher dose is above the BNF quoted maximum of 200mg per day, and should only be considered if clinically required, after appropriate counselling with the patient, and with clear criteria for dose reduction.

Dose requirements can change over time and some patients may go into remission.

Therefore, once symptoms are well controlled for a period of time gradual dose reduction should be tried to maintain the lowest effective dose or, if there is no recurrence on each dose reduction, withdrawal during remission periods.

Gastrointestinal side effects with indomethacin are common and may preclude use of the drug. A concomitant proton-pump blocker or H2-antagonist can be used.