



## Case Report: occipital headache with ipsilateral autonomic symptoms

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### Introduction

Trigeminal autonomic cephalalgias (TACs) are primary unilateral headaches that typically affect the trigeminal territory, most commonly the V1 division. They are accompanied by prominent autonomic symptoms such as eyelid edema, ptosis, miosis, lacrimation, and eye redness. Atypical presentations, such as bilateral cluster headaches, have been described in the literature.

### Objective

To report a case of a short-lasting, recurrent occipital headache associated with ipsilateral autonomic features and the response to indomethacin during follow-up at the Central Institute of the University of Medicine at the University of São Paulo.

### Case Report

A 64-year-old female patient with a personal history of restless legs syndrome, obstructive sleep apnea, arterial hypertension, depressive disorder, and critical cervical spinal canal stenosis with arthrodesis in 2010 presents with headaches that began 20 years ago. The headaches were unilateral and occipital, lasting four minutes, with an average frequency of four episodes daily, associated with tearing and eyelid ptosis ipsilateral to the pain. Additionally, the patient reports a second daily neck pain related to movement. On examination, there was mild pain on palpation of the greater and lesser occipital nerves on the left and pain in the area of the bilateral trapezius muscle. Over the years, various treatment attempts, including gabapentin, lamotrigine, amitriptyline, topiramate, botulinum toxin, and verapamil, were unsuccessful. Melatonin was introduced, resulting in a slight improvement in frequency, and subsequently, indomethacin was initiated. Currently, with the use of indomethacin 50 mg daily, combined with melatonin 5 mg, there has been a significant reduction in the frequency of pain, decreasing to weekly episodes. Complementary tests included skull resonance with intracranial arterial and venous angiography from 2017, which showed no abnormalities.

### Conclusion

We report a patient with occipital headache associated with atypical trigeminal activation that does not meet the criteria for paroxysmal hemicrania, cluster headache, SUNCT/SUNA, or migraine. However, there is a notable response to indomethacin.