



Case report: a paroxysmal hemicrania responsive to verapamil

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Introduction

Paroxysmal hemicrania (PH), a trigeminal autonomic headache, is characterized by unilateral pain in the orbital, supraorbital, and temporal regions, accompanied by nasal congestion and ocular hyperemia, with a predominance (not exclusively) in women, with attacks lasting 2 to 30 minutes and occurring several times daily. Pain crises have been known to cease completely or almost completely with the use of indomethacin. However, in some patients, the side effects caused by taking the drug prevent continuation of treatment. There is also the possibility of a partial response to the first-line drug. In these cases, alternative drugs are chosen, with verapamil being one of the drugs of choice.

Objectives

In this report, we present a case of a patient with a partial response to the first-line drug therapy and good responsiveness to verapamil.

Methods

We collected patient data through the electronic medical record. Afterward, we reviewed the literature regarding paroxysmal hemicrania and its responsiveness to indomethacin and verapamil.

Results

A 56-year-old woman presented with a 1-year history of throbbing pain in the left hemiface, and retro-orbital and temporal ipsilateral pain, lasting approximately 30 minutes with a frequency of 5-6 episodes per day and a maximum remission period of 3 months. The headache attacks were associated with nasal congestion and allodynia and had worsened recently. Her medical history was positive for major depressive disorder and hypertension. At the time she presented, she was taking carbamazepine 900 mg per day, which resulted in partial relief of pain. Clinical examination revealed pain on palpation of the trigeminal branches on the left side, bilateral temporomandibular pain, and pain on palpation of the right greater occipital nerve. Magnetic resonance angiography of the head showed no abnormalities. To manage the headache attacks, treatment with indomethacin 300 mg was started at the onset of the pain episodes, along with chlorpromazine 6 mg per day and carbamazepine 200 mg per day, which decreased the intensity of the pain but had no effect on the frequency of the attacks. Therefore, verapamil 80 mg per day was started, with continued use of the previously prescribed medications. Given the normal ECG result, the dose of verapamil was increased to 240 mg per day, and carbamazepine was discontinued. The patient progressed with only two mild episodes of pain per month.

Conclusion

Responsiveness to indomethacin is an important diagnostic criterion for paroxysmal hemicrania, yet some patients have an incomplete response to this therapy. The use of alternative therapies is limited by the lack of research and evidence supporting treatment with other drugs. Among possible therapies, verapamil appears to be a potential therapeutic option for PH with partial response to indomethacin. The present case report describes a chronic PH with partial response to indomethacin and adequate control of symptoms after combination with prophylactic therapy with verapamil.

Keywords: Paroxysmal hemicrania, Trigeminal autonomic cefalalgias, Indomethacin, Verapamil.