CLUSTER HEADACHE

To the editor: I read with interest your excellent review of cluster headaches (July/August 1996).[1] I would like to comment on the statement that the administration of local anesthetics into the nose, and "perhaps anesthetizing the sphenopalatine ganglion...is not commonly used...as administration is cumbersome at best."[1]

Actually, the initial report of nasal and sphenopalatine ganglion blockade dates to 1910 and the description of "Sluder's neuralgia."[2] This is now considered to be cluster headache.

The amount of cocaine used is approximately 40 mg per treatment, and in my experience the average patient requires five sessions to break the cycle. In many patients, no further therapy is required for several months.

The technique is straightforward to the knowledgeable clinician. We have designed special stainless steel applicators, tipped with cotton, and instill two applications in each nasal passage. The local anesthetic we use is 0.75% marcaine and 1:100 000 epinephrine, (as described by the Baylor group).[3] We have abandoned the use of lidocaine as unpredictable. The diffusing capacity of the anesthetic is important.

In Canada, ultracaine has been used and is extremely diffusible and is more predictable in achieving nerve blockade. Cocaine is probably the most useful. This is infrequently used because there is irrational concern that the small amounts used in practice are harmful.

We agree that a favorable response can be obtained. The efficacy of sphenopalatine ganglion blockade has been observed at Cleveland Clinic Florida, Department of Internal Medicine. In particular, an example was presented at the International Association for the Study of Pain in Vancouver on August 19, 1996.[4] This describes 52 patients with post-herpetic neuralgia.

Comparison of patients receiving sphenopalatine ganglion blockade within 90 days of onset of pain and those seen after 90 days of disease revealed a *P* value of .0071. This indicates that early autonomic blockade, (presumably sympathetic), is efficacious in herpes zoster. This could prevent post-herpetic neuralgia. We are continuing to study these patients.

I would suggest that the technique of properly applied sphenopalatine ganglion blockade should be more widely available as a useful modality in the treatment of pain.

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