

# Deep brain stimulation for intractable trigeminal autonomic cephalalgias

Interventional procedures guidance

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[www.nice.org.uk/guidance/ipg381](http://www.nice.org.uk/guidance/ipg381)

## 1 Guidance

- 1.1 Current evidence on the efficacy of deep brain stimulation (DBS) for intractable trigeminal autonomic cephalalgias (TACs) is limited and inconsistent, and the evidence on safety shows that there are serious but well-known side effects. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research.
- 1.2 Clinicians wishing to undertake DBS for intractable TACs should take the following actions:
  - Inform the clinical governance leads in their Trusts.

- Ensure that patients and their carers understand the uncertainty about the procedure's efficacy. They should be specifically informed that DBS may not control their headache symptoms and they should be fully informed about the possible risks associated with the procedure, including the small risk of death. Clinicians should provide them with clear written information. In addition, the use of NICE's [information for patients](#) ('Understanding NICE guidance') is recommended.
  - Audit and review clinical outcomes of all patients having DBS for intractable TACs (see section 3.1).
- 1.3 Patient selection for DBS for intractable TACs should be carried out by a multidisciplinary team specialising in pain management.
- 1.4 Further research studies should clearly define patient selection and report the intensity and duration of stimulation, medication use and quality of life, in addition to documenting the effects on headache symptoms as clearly as possible.

## 2 The procedure

### 2.1 Indications and current treatments

- 2.1.1 TACs (for example cluster headaches) are characterised by relatively short-lasting but severe pain attacks associated with autonomic manifestations such as sweating, flushing, and ipsilateral rhinorrhea.
- 2.1.2 The first-line treatment for TACs is usually medical therapy, carried out with the aim of either preventing or limiting the duration of episodes. Surgery to interrupt the trigeminal sensory or autonomic pathways is sometimes used, but this has a risk of serious complications including diplopia and corneal ulcers.

### 2.2 Outline of the procedure

- 2.2.1 DBS involves stereotactic targeting of specific anatomical sites within the brain (such as the sensory thalamus or periaqueductal grey matter) to

modulate the central processing of the pain signals.

- 2.2.2 DBS for intractable TACs is usually carried out with the patient under local anaesthesia and/or intravenous sedation. Electrodes are inserted into the brain using magnetic resonance imaging and/or computed tomography. A test stimulation (or macrostimulation) is used to check for side effects. Postoperative scans may be used to assess the position of the electrodes and to identify complications such as local haemorrhage.
- 2.2.3 Following satisfactory electrode testing, a pulse generator is implanted under the chest wall and connected by tunnelled wires to the electrodes. The generator usually remains switched 'on'.

Sections 2.3 and 2.4 describe efficacy and safety outcomes from the published literature that the Committee considered as part of the evidence about this procedure. For more detailed information on the evidence, see the [overview](#).

## 2.3 Efficacy

- 2.3.1 A crossover randomised controlled trial (RCT) of 12 patients with refractory chronic cluster headache (CH) reported that there was no significant difference between the 'on' and 'off' periods in either the 'on-off' group or the 'off-on' group for a number of outcomes including frequency of attacks, pain intensity and patient satisfaction.
- 2.3.2 During a 10-month open phase of the RCT of 12 patients, when all patients received DBS, the mean weekly attack frequency decreased by 48% from baseline (from a median of 14 to 8 attacks per week;  $p = 0.08$ ).
- 2.3.3 A case series of 20 patients reported that all 16 patients treated for refractory chronic CH had relief from pain at a mean follow-up of 23 months. Time to response occurred at a mean of 42 days (range 1 to 86 days) with mean 71% of pain-free days.
- 2.3.4 The RCT of 12 patients reported reduced Hospital Anxiety and Depression Scale scores (7 anxiety items and 7 depression items with

scores greater than 7 indicating anxiety and depression, respectively) in the open phase only. Median anxiety scores decreased from 13 to 7.5 ( $p = 0.008$ ) and median depression scores decreased from 10 to 4.5 ( $p = 0.052$ ).

- 2.3.5 The Specialist Advisers listed key efficacy outcomes as improvement in the number of headaches, severity and duration of attacks, and quality of life, measured by headache scoring systems.

## 2.4 Safety

- 2.4.1 In a case series of 6 patients with unilateral refractory chronic CH, 1 patient died 3 days after the procedure from an intracerebral haemorrhage which developed along the lead tract a few hours after the procedure.
- 2.4.2 The RCT of 12 patients reported subcutaneous infection 3 weeks after surgery in 1 patient, and the case series of 21 patients reported 1 occurrence of deep infection. Both resolved after hardware removal and antibiotic treatment.
- 2.4.3 In the RCT of 12 patients, 1 patient developed transient loss of consciousness with hemiparesis shortly after test stimulation and subsequent severe micturition syncope associated with a decrease in blood pressure in the standing position (not otherwise described).
- 2.4.4 The case series of 6 patients reported that all patients had diplopia and dizziness if high levels of electrical stimulation were used (above 1.5 V). One patient became tachypnoeic and tachycardic but symptoms resolved after the recording electrode was removed.
- 2.4.5 The Specialist Advisers listed anecdotal adverse events as stroke, seizures and lead migration.

## 2.5 Other comments

- 2.5.1 The Committee found interpretation of the evidence difficult: the single

RCT dealt only with a subgroup of patients.

- 2.5.2 The Committee noted patient commentary, which reported improvements in quality of life, even if pain was relieved only partially, and noted that some patients were no longer suicidal after treatment.

## 3 Further information

- 3.1 This guidance requires that clinicians undertaking the procedure make special arrangements for audit. NICE has identified relevant audit criteria and has developed an [audit tool](#) (which is for use at local discretion).
- 3.2 For related NICE guidance see our [website](#).

### Information for patients

NICE has produced [information on this procedure for patients and carers](#) ('Understanding NICE guidance'). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

## 4 About this guidance

NICE interventional procedure guidance makes recommendations on the safety and efficacy of the procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS. It is for healthcare professionals and people using the NHS in England, Wales, Scotland and Northern Ireland, and is endorsed by Healthcare Improvement Scotland for implementation by NHSScotland.

This guidance was developed using the NICE [interventional procedure guidance](#) process.

We have produced a [summary of this guidance for patients and carers](#). Tools to help you put the guidance into practice and information about the evidence it is based on are also [available](#).

### Changes since publication

2 January 2012: minor maintenance.

## Your responsibility

This guidance represents the views of NICE and was arrived at after careful consideration of the available evidence. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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# Endorsing organisation

This guidance has been endorsed by [Healthcare Improvement Scotland](#).

## Accreditation

