

Distinguishing ‘ Suicide Headache’ From Migraine: Cluster Headache’s Unusual Features

Indu Subramanian, MD; Andrew C. Charles, MD

September 01, 2026

This transcript has been edited for clarity.

Indu Subramanian, MD: Hi. Welcome, everyone, to Medscape. We’re so excited to have you here, and I’m very excited to have my friend and colleague, and former residency program director, Professor Andrew Charles, with us today. Welcome, Andy.

Andrew C. Charles, MD: Thanks very much. Good to be with you, Indu.

Cluster Headache Devastating and Underdiagnosed

Subramanian: My name is Indu Subramanian. I’m joining you from UCLA, which is where Andy also works. We’re excited to talk today about [cluster headache](#). It’s one of the lesser-known headaches. Andy, maybe you could tell us a little bit about this type of headache. I’ve just been so fascinated by how underdiagnosed this is and how devastating it can be for the person suffering.

Charles: It is indeed underdiagnosed. Very often, it takes p
months to get a diagnosis. It’s thought of as a rare disorder, but it’s not that

✦ [Ask Medscape AI](#)

rare. About [1 in 1000 people have cluster headache](#). Its presentation is somewhat like [migraine](#), but in many ways very different, with some really unusual features.

It's called "cluster headache" because it tends to occur in clusters. It happens every single day or every other day for weeks or months at a stretch, and then it goes into remission, and it doesn't happen at all until often, interestingly, the same time of year the following year. This distinctive seasonal timing is one of its features.

The other is that it very typically happens at the same time of day, typically around bedtime. Some people can set their watch by when it's going to happen every day. There's this clearly circadian day-night cycle feature that's very interesting, and we still don't have any clear understanding of what it is. We think that it might tell us something about the changes in the brain during sleep and wakefulness

The 'Suicide Headache' Brings Agitation

Subramanian: Very interesting. Could you tell us a little bit more about how these patients present? What is the quality of the pain? How can we tell it apart from other types of headaches?

Charles: That's another important thing to consider. Again, some of the features are migraine-like. It's an excruciating headache, described by patients as the worst pain they've ever experienced. It's known as a [suicide headache](#), in part because of the severity of pain, but in part because of this very interesting phenomenon of agitation that happens with it.

Whereas people with migraine tend to lie still in a dark, quiet room, patients with cluster headache pace, bang their heads, or scream. They do all these things that migraine patients don't do as part of their cluster attacks. That sort of agitation is really a hallmark. One way of distinguishing cluster from migraine is you ask, "What do you do when you get one?" If somebody says they pace around and bang their head, that's usually going to be cluster.

That sort of agitation is also part, we think, of what causes patients to think about harming themselves during the attacks — because again, it's not just the excruciating pain, but this sort of emotional agitation that

The pain is typically in the eye or somewhere around the eye. It's called a [trigeminal autonomic cephalalgia](#) because it's associated with cranial autonomic symptoms. Redness and tearing of the eye, runny nose, and drooping eyelid are the most common ones. Basically, anytime you have a headache that's around the eye, that happens at the same time of day every day for some period of time, and that's more common in men than women, those sorts of features are what really set cluster headache apart from migraine.

***New York Times* Author and Cluster Headache Patient**

Subramanian: Wow. It's not that uncommon, you said?

Charles: Well, 1 in 1000, so that sounds rare, but we see it all the time in headache clinics. It's probably more common than that, in fact, because it's just getting misdiagnosed as migraine. There are some very specific treatments that are different from migraine, so it's very important to make an appropriate diagnosis because you can really end up much more effectively treating patients if you diagnose it appropriately.

Subramanian: I love the book [The Headache: The Science of a Most Confounding Affliction](#) that you were featured in by our friend, the amazing *New York Times* [author](#) who wrote about this whole area. Could you tell us about that book?

Charles: Tom Zeller, Jr, is, as you mentioned, a *New York Times* writer, and as he identifies in the book, he's a cluster headache patient. He describes in great detail his own experience with cluster and also his frustrations with achieving an appropriate diagnosis, with treatment, and with the fact that very little attention has been paid to cluster headache in terms of funding or research to try and identify its cause.

Subramanian: It's a beautiful book, and a must-read I would say for many of us neurologists who are seeing some of these folks.

Thank you so much, Andy. It's been amazingly educational.

Charles: My pleasure.

✦ [Ask Medscape AI](#)

Subramanian: See you, everyone.

Credits

Lead image: Medscape, LLC

Medscape Neurology © 2026 WebMD, LLC



Any views expressed above are the author's own and do not necessarily reflect the views of WebMD or Medscape.

Cite this: subramanian I, Charles AC. Distinguishing 'Suicide Headache' From Migraine: Cluster Headache's Unusual Features - Medscape - September 01, 2026.

✓ [Privacy & Legal](#)

Commonly Asked by HCPs

Q: What secondary causes should be excluded in suspected cluster headache?

A: Suspected cluster headache warrants consideration of secondary causes when the presentation is atypical, new-...

[Read full answer >](#)

Q: How do circadian patterns influence diagnosis and management of cluster headache?

A: Cluster headache often shows circadian and circannual timing, with attacks occurring at similar times of day and in seasonal...

[Read full answer >](#)

Q: How is differentiating cluster headache from migraine?

A: Cluster headache often shows circadian and circannual timing, with attacks occurring at similar times of day and in seasonal...

[Read full answer >](#)

 Ask your own question

Top Psychiatric Predictors of CVD Risk After Trauma Revealed

Megan Brooks

September 04, 2026

 [Ask Medscape AI](#)

Psychiatric disorders diagnosed in the aftermath of a traumatic event were associated with higher odds of subsequent major adverse cardiac and cerebrovascular events.

Results of a large Danish registry study showed alcohol use disorder (AUD) was the leading psychiatric predictor in both men and women. Depressive disorders, posttraumatic stress disorder (PTSD)/stress-related disorders, brain-related or physiologic conditions, and delirium were also among the top predictors.

“Experiencing traumatic events can significantly affect mental health as well as cardiovascular health,” lead author Jennifer A. Sumner, PhD, associate professor in the Department of Psychology at the University of California, Los Angeles, said in a news release.

“Although most work to date has focused on PTSD and cardiovascular health, our research suggests that we should think about a wide range of mental health consequences when looking at cardiovascular disease risk after trauma,” Sumner added.

The study was [published online](#) on September 2 in the *Journal of the American Heart Association*.

Looking Beyond PTSD

Research on posttraumatic psychopathology and cardiovascular disease (CVD) has largely focused on PTSD, leaving the cardiovascular risks associated with other psychiatric disorders that emerge after trauma poorly characterized.

To examine these associations, the researchers conducted a matched case-control study nested within a cohort of adults in Denmark

✦ [Ask Medscape AI](#)

traumatic event between 1995 and 2018.

Such events included fires or explosions, transportation accidents, serious medical complications or injuries, traumatic brain injury, physical assault, stillbirth or pregnancy-related trauma, and suicide of a family member.

Among 219,866 adults, 43,994 subsequently experienced a major adverse cardiac or cerebrovascular event (MACCE), defined as nonfatal myocardial infarction, nonfatal stroke, coronary revascularization, or cardiovascular death.

Each case was matched with four trauma-exposed control individuals who had not experienced a MACCE, based on sex, age, year of trauma, and the date of the cardiovascular event.

The researchers identified psychiatric disorders diagnosed within 3 years after trauma and before the cardiovascular event, then used sex-stratified machine-learning models to identify the most important psychiatric predictors of subsequent MACCE.

The models evaluated a broad range of conditions, including substance use, depressive, bipolar, anxiety, stress-related, psychotic, and personality disorders.

“This study is unique in that it covers a wide range of traumatic experiences and considers a variety of mental health conditions that can start after these events as potential predictors of cardiovascular disease,” Sumner said.

Top Psychiatric Predictors

AUD emerged as the most important psychiatric predictor of MACCE in both men and women. Among men, its importance in the machine-learning model was about 10-fold greater than that of depressive episodes, the second-ranked predictor. Among women, AUD also ranked first, but depressive episodes were a much closer second.

After adjustment for sociodemographic factors, AUD was associated with 64% higher odds of MACCE among men and 85% higher odds among women in the testing samples. Depressive episodes were associated with 51% and 78% higher odds of MACCE among men and women, respectively.

PTSD/stress-related disorders also ranked among the leading predictors. In adjusted analyses of the testing samples, the association was not statistically significant in men (odds ratio [OR], 1.20; 95% CI, 0.88-1.64) but was significant in women (OR, 1.91; 95% CI, 1.41-2.59).

Other prominent predictors included recurrent depression, schizophrenia, anxiety disorders, bipolar disorder, personality disorders, nonsubstance-induced delirium, and disorders attributable to brain damage or physical disease.

Some sex-specific differences also emerged. Cannabis- and opioid-related substance use disorders ranked among the most important predictors only in men, whereas persistent mood and delusional disorders and sedative-related substance use disorders ranked among the leading predictors only in women.

Implications and Limitations

Taken together, the findings suggest that psychiatric disorders beyond PTSD may also be relevant to cardiovascular risk after trauma, the researchers noted. However, they cautioned that these diagnoses should be viewed as risk markers rather than independent or causal CVD risk factors.

The observed associations may reflect a combination of behavioral pathways, including smoking, physical inactivity, poor diet, sleep disruption, poor adherence to medical care, and biological mechanisms such as autonomic and hypothalamic-pituitary-adrenal axis dysregulation and chronic systemic inflammation.

The researchers characterized the findings as hypothesis-generating. Traditional cardiometabolic risk factors, including hypertension, hyperlipidemia, and diabetes, were intentionally excluded from the machine-learning models, and lifestyle and clinical cardiovascular risk factors were not modeled.

The researchers characterized the findings as hypothesis-generating, noting that the models were designed to identify psychiatric predictors rather than optimize CVD risk prediction.

Traditional cardiometabolic risk factors, including hypertension, hyperlipidemia, and diabetes, were therefore intentionally excluded, and

lifestyle and clinical cardiovascular risk factors were not modeled.

The investigators were also able to determine whether associations differed between coronary and cerebrovascular outcomes. The findings may also have limited generalizability beyond Denmark, which has universal healthcare and differs from many countries in social determinants of health.

“Traumatic experiences which lead to mental health disorders can have lasting effects on the risk of developing heart disease,” Glenn N. Levine, MD, who was not involved in the study, said in the news release.

“By recognizing trauma, seeking mental health support, and managing cardiovascular risk factors, we may help mitigate this risk,” added Levine, who is a professor of medicine at Baylor College of Medicine and cardiology section chief at the Michael E. DeBakey VA Medical Center, both in Houston.

This study had no commercial funding. Author disclosures are available in the original publication.

Credits

Lead image: iStock/Getty Images

Medscape Medical News © 2026 WebMD, LLC

Send comments and news tips to news@medscape.net.

Cite this: Brooks M. Top Psychiatric Predictors of CVD Risk After Trauma Revealed - Medscape - September 04, 2026.

✓ [Privacy & Legal](#)

Commonly Asked by HCPs

Q: What follow-up strategies reduce cardiovascular risk in patients with post-trauma psychiatric illness?

A: Follow-up strategies typically emphasize coordinated mental health treatment, lifestyle risk reduction, blood pressure and li...

[Read full answer >](#)

Q: When should trauma-exposed patients be screened for depression, PTSD, and substance use disorders?

A: Screening is usually considered when trauma survivors show persistent distress, sleep disruption, impaired function,...

[Read full answer >](#)

**Q: How s
cardiovas
psycholo**

A: Cardio
aft → au
beyond tr
include m

[Read full](#)

 [Ask Medscape AI](#)

✦ Ask your own question

✦ Ask Medscape AI