

Headache pathway (adults)

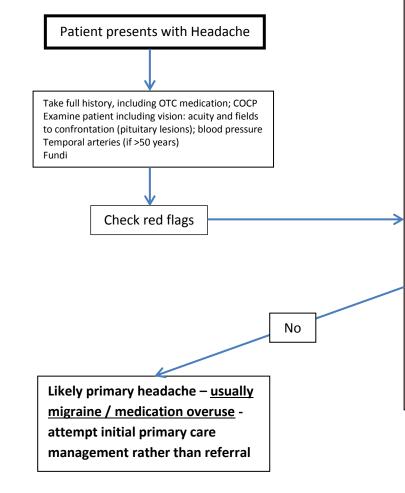


Key Points

- Most headache is <u>migraine</u> (intermittent or chronic) – probably up to 90%
- Stress, sinuses, eyesight are not usually causes of headaches
- MOH is <u>common</u> and underdiagnosed; if suspected stop analgesics and caffeine intake
- Review medication (COCP in migraine, medication overuse headache - MOH)
- Consider age of patient (>50) temporal arteritis
- Ask about activity in attacks rest in migraine; restless in cluster headache
- Ask about <u>duration</u> continuous, intermittent, paroxysmal
- If continuous was it intermittent first or continuous from onset (new daily persistent headache – NDPH)
- NB NDPH is usually <u>recent</u> and continuous (see red flags)
- Chronic migraine is usually <u>longstanding</u> and continuous – and previously intermittent
- Trigeminal neuralgia is paroxysmal
- Tailor medication to diagnosis
- Do not use opioids in headaches
- Few headaches respond to regular analgesics or triptans

Refer:

- Cases with red flags (see opposite)
- New daily persistent headache
- Trigeminal neuralgia;
- SUNCT/SUNA
- Cluster headache
- HC / CPH
- Refractory / chronic migraine
- Unclassifiable, atypical headache or failure to respond to standard migraine therapies.



Abbreviations:

OTC - over the counter

MOH - medication overuse headache

COCP- combined oral contraceptive pill

NDPH – new daily persistent headache

SUNCT – severe unilateral neuralgiform headache with conjunctival injection + tears

SUNA - severe unilateral neuralgiform headache with autonomic features (peri-ocular swelling usually)

CPH – chronic paroxysmal hemicrania

HC - hemicrania continua

SAH – subarachnoid haemorrhage

ICP - intracranial pressure

TN – trigeminal neuralgia

Red Flags

- Thunderclap headache (intense headache of "explosive" onset suggest SAH)
- Visual loss ? pituitary lesions, raised ICP
- papilloedema
- Age >50 / Scalp tender / Jaw claudication: check urgent ESR /CRP (if suspected temporal arteritis - refer & start steroids immediately, prednisolone 40-60mg daily, 60mg if visual symptoms; see BNF))
- Headache with atypical aura (duration >1 hour, or including significant / prolonged motor weakness)
- Headache associated with postural change (bending), straining, exertion or coughing or waking from sleep (possible raised ICP)
- Pain worse / occurring upright (postural) low CSF pressure headache
- New daily persistent headache
- Unilateral red eye consider angle closure glaucoma
- Remember carbon monoxide poisoning (also causes lethargy + nausea)
- Rapid progression of sub-acute focal neurological deficit
- Rapid progression of unexplained personality / cognitive / behavioural change
- New onset headache in a patient with a history of cancer / immunosuppression
- Progressive headache, worsening over weeks or longer
- Refractory headache
- Unclassified headache



- Walton Centre advice line: Weekdays 11.30-1.30 (<u>07860 481429</u>)
- Open access MR scan if available
- Refer
- Admit

(As clinically appropriate)



Headache (adults) - primary care guidance



Migraine

(usual cause of chronic headaches)

Diagnosis - at least 5 attacks fulfilling these criteria:

- Lasts 4-72 hours untreated
- At least 2 of the following
 - Unilateral location
 - Pulsating quality
 - Moderate/severe pain
- Nausea / vomiting and/or photophobia
- No other cause identified

Usually episodic

Can be chronic (15% of cases) with both featureless and migrainous headaches on >15 days a month; of which 8 migrainous



Migraine – acute therapy

- Simple analgesia (aspirin, paracetamol, NSAID) or
- Simple analgesia + triptan if not effective or
- Simple analgesia + triptan + prokinetic antiemetic

Triptan options – oral, orodispersible, nasal, injection Oral absorption can be unreliable in acute migraine Avoid COCP if any aura / severe migraine No triptan DURING aura



Migraine – prophylactic therapy options

- Stop caffeine intake; avoid excess analgesics (medication overuse)
- Propranolol 80-240mg daily
- Topiramate 25mg od 2 weeks; 25mg bd 2 weeks; then 50mg bd
- Gabapentin 300mg increasing to 900mg tds (unlicensed)
- Sodium Valproate up to 1600mg daily (not in young women)
- Candesartan 8-16mg daily (limited evidence; unlicensed)
- Amitriptyline (unlicensed), pizotifen, (limited effectiveness/ tolerability) NB teratogenic risk (avoid valproate; caution with topiramate in child bearing age women); enzyme induction with Topiramate (contraceptive failure); cognitive and glaucoma risks with Topiramate; sedation (driving hazard) with amitriptyline / pizotifen

Botulinum toxin in chronic refractory cases (3 failed preventatives and no analgesic overuse) Red

Migraine with aura

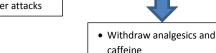
Occurs in 1/3 of migraine patients

Aura 5-60 minutes prior to / with headache

Usually visual - note blurring & spots not diagnostic

Can be speech / motor / sensory

Full recovery after attacks



caffeine

• prn ibuprofen / naproxen very sparingly

Medication overuse

Medication history is

crucial especially use of

over the counter analgesia

Triptans / opioids > 10 days

• Simple analgesics > 15 days

· Usually underlying migraine

a month for >3 months

a month for >3 months

· Usual acute migraine

therapy ineffective

· Consider low dose amitriptyline 10-75mg nocte (unlicensed)

Headaches will worsen for 7-10 days (weeks if coming off (abioigo

Migraine therapy may be needed if intermittent migrainous features persist or emerge

Tension type headache

Usually episodic; can be chronic

Deemed chronic if >15days per month

Featureless, bilateral, mild or moderate

Not worse with activity

Mild - moderate intensity

Can occur in combination with migraine



- · Simple analgesics but avoid medication overuse (>15 days / month)
- Treat any medication
- Acupuncture 10 sessions over 5-8 weeks if available
- Amitriptyline 10-75mg nocte - limited evidence of effectiveness (unlicensed)

Cluster headache

- Affects M:F (3:1 ratio)
- Usually aged 20+ years
- Bouts last 6-12 weeks.
- Usually occur 1-2x year
- · Rarely chronic throughout year.
- Very severe often at night & lasts 30-60 minutes rarely up to 120 mins
- Restless, agitated
- Triggered by alcohol
- Unilateral periorbital
- Ipsilateral conjunctival injection, rhinorrhea +/-Ptosis



Acutely

- Nasal or sc triptan prn
- 100% Oxygen 15L/min (consult neurology; not if patient is a smoker / uses E cigarettes)

Termination of cluster

- Prednisolone 60mg daily reduce by 10mg every 3 days
- Verapamil 80mg tds increased to 120mg tds if needed (may need 240mg tds or more: start at same time as steroids; unlicensed)
- ECG weekly if >120 tds (hospital if not possible in primary care)
- · Refer all cluster cases for specialist review + MRI

Others

Trigeminal neuralgia

- Triggered unilateral facial pain
- Sudden paroxysmal
- Not continuous

SUNCT / SUNA

- Similar to TN (but frontal area)
- Autonomic ocular features

Ice pick / stabbing

- Sudden brief head pains
- Various locations

Chronic Paroxysmal Hemicrania (CPH)

- Unilateral periorbital
- Autonomic (red eye, lacrimation, nasal congestion, ptosis
- 15-30 minutes; multiple / day

Hemicrania continua (HC)

- Unilateral "side-locked" constant headache
- >3 month
- +/- autonomic features
- Restlessness



TN: carbamazepine 100-200mg daily: gradually increased to effect: lamotrigine (unlicensed) or phenytoin if allergic to carbamazepine

SUNCT / SUNA: Lamotrigine increased to 200mg daily (unlicensed)

Ice-pick / hemicrania continua/CPH: Indometacin 25-50mg tds (unlicensed) with PPI cover

Green All drugs listed above are classified as Green and may be initiated in primary care, except where individually stated otherwise.