Headache pathway (adults)

NHS Pan Mersey Area Prescribing Committee

Key Points

- Most headache is migraine (intermittent or chronic) – probably up to 90%
- Stress, sinuses, eyesight are not usually causes of headaches
- MOH is common – 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 duration – continuous, intermittent, paroxysmal
- If continuous – was it intermittent first or continuous from onset (new daily persistent headache – NDPH)
- NB – NDPH is usually recent and continuous (see red flags)
- Chronic migraine is usually longstanding 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.**

Patient presents with Headache

Take full history, including OTC medication; COCP
Examine patient including vision: acuity and fields to confrontation (pituitary lesions); blood pressure
Temporal arteries (if >50 years)
Fundi

Check red flags

No

Likely primary headache – usually migraine / medication overuse - attempt initial primary care management rather than referral

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

Yes

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

(As clinically appropriate)

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

Headache (adults) – primary care guidance

NHS Pan Mersey Area Prescribing Committee

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 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

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

Medication overuse

Medication history is crucial especially use of over the counter analgesia

- Triptans / opioids > 10 days a month for >3 months
- Simple analgesics > 15 days a month for >3 months
- Usually underlying migraine
- Usual acute migraine therapy ineffective

- Withdraw analgesics and caffeine
- prn ibuprofen / naproxen very sparingly
- Consider low dose amitriptyline 10-75mg nocte (unlicensed)

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

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 overuse
- 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.