Headache pathway (adults)

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

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

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

Abbreviations:
- Walton Centre advice line:
  - Weekdays 11.30-1.30 (07860 481429)
- 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 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

**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

**Tension type headache**

Usually episodic; can be chronic

Deemed chronic if >15 days per month

Featureless, bilateral, mild or moderate

Not worse with activity

Mild – moderate intensity

Can occur in combination with migraine

**Migraine – acute therapy**

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

**Migraine – prophylaxis 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)
- Cedansartan 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)

**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

**Cluster headache**

- Nasal or sc triptan pnr
- 100% Oxygen 15L/min (consult neurology; 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)

**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

**Hemicrania continua (HC)**

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

**Chronic Paroxysmal Hemicrania (CPH)**

- 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

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