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)
Fundus

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

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

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
  - Lasts 4-72 hours

- **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
    - 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

- **Cluster headache**
  - Affects M:F (3:1 ratio)
  - Usually aged 20+ years
  - 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

- **Other headaches**
  - Trigeminal neuralgia
    - Trigeminal 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

**Medication history**

- **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)**

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

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**Red**

- **Indomethacin 25-50mg tds (unlicensed) with PPI cover**
- **Lamotrigine (unlicensed) or phenytoin if allergic to carbamazepine**

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**Others**

- **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)
- **Hemicrania continua (HC)**
  - Oral analgesics first
  - Carbamazepine 100-400mg daily
  - 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

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**Cluster headache**

- **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)

- **Other options**
  - Carbamazepine
  - Lamotrigine (unlicensed) or phenytoin if allergic to carbamazepine
  - Indomethacin 25-50mg tds (unlicensed) with PPI cover
  - **Other action**
    - Opioid
    - Opioid + tricyclic antidepressant
    - Opioid + prokinetic antiemetic
    - Opioid + nonsteroidal anti-inflammatory drug
    - Opioid + gabapentin
    - Opioid + lamotrigine
    - Opioid + botulinum toxin