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

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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 → Red Flags

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) + aspirin 75mg if no contraindication
- 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

No →

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

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 + tearing
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

Migraine (usual cause of chronic headaches)

Diagnosis-at least 5 attacks fulfilling these criteria;

- Last 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

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 >15 days per month

Featureless, <u>bilateral</u> , 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 mins- rarely up to 120 mins
- Restless, agitated
- Triggered by alcohol
- Unilateral periorbital
- Ipsilateral conjunctival injection, rhinorrhoea +/- 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 240 mg tds or more; start at same time as steroids)
- ECG initially, after dose increases and weekly if >120 tds (hospital if not possible in primary care)
- Refer all cluster cases for specialist review + MRI

Others

<u>Trigeminal neuralgia</u>

- Triggered <u>unilateral</u> facial pain
- Sudden paroxysmal
- Not continuous

<u>SUNCT/SUNA</u>

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

<u>Ice pick/ Stabbing</u>

- Sudden brief head pains
- Various locations

<u>Chronic Paroxysmal Hemicrania</u>

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

<u>Hemicrania Continua (HC)</u>

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

<u>TN</u>; carbamazepine 100-200mg daily; gradually increased to effect; lamotrigine (unlicensed) or phenytoin if allergic to carbamazepine

<u>SUNCT/SUNA;</u> Lamotrigine increased to 200mg daily (unlicensed)<u>. Ice-pick/ hermicrainia continua/CPH:</u>

Indometacin 25-50mg tds (unlicensed) with PPI cover

Headache (adults) – primary care guidance

Migraine – Prophylactic therapy options (try for 3 months):

- Stop caffeine intake; avoid excess analgesics (medication overuse)
- **Propranolol** - 80-240mg daily
- **Topiramate** - 25mg od 2 weeks; 25mg bd 2 weeks; then 50mg bd
    - **Males**
    - **Females of childbearing potential aged 10-55yrs (SEE ADJACENT WARNING)**
- **Candesartan** - 8-16mg daily
- **Amitriptyline** - 10-75mg **(nortriptyline if better tolerated)**
- **Cranial acupuncture if available**
- **Sodium valproate** - up to 1600mg daily
    - **Males**
    - **Females of childbearing potential aged 10-55yrs (SEE ADJACENT WARNING)**
- **Botulinum toxin -** in chronic refractory cases (3 failed preventatives; no analgesic overuse)
- **New CGRP antagonists**

The preventative medication dose should be escalated up until the best tolerated dose is reached . As a practical rule start at a low dose and gradually increase the dose aiming for the mid point of the therapeutic dose range . Then the drug should be continued for at least 2- 3 months to assess benefit, using headache diaries to monitor.

If the medication is not beneficial it should be tapered off and the same strategy applied for the next preventive medication

If the medication is found to be effective – it should be continued for a further 6-9 months. Provided the patient's symptoms remain well controlled, an attempt can be made to withdraw and stop the medication at that stage . If symptoms recur, the patient has to go back on the medication

NB; Valproate medicines must not be used in women of childbearing potential, aged 10-55yrs, unless the Pregnancy Prevention Programme is in place and only if other treatments are ineffective or not tolerated, as judged by an experienced specialist. Pregnancy should be excluded before treatment initiation and highly effective contraception* must be used during treatment. For details, see the 'Antimigraine Drugs' section of the local CNS formulary.

*** Methods of contraception considered 'highly effective' in this context include the long-acting reversible contraceptives (LARC): copper intrauterine device (Cu-IUD), levonorgestrel intrauterine system (LNG-IUS), and progestogen-only implant (IMP).**

Topiramate is contraindicated in pregnancy - highly effective contraception is required prior to initiation and during treatment. Advise women and girls of childbearing potential that topiramate is associated with a risk of foetal malformations and can impair the effectiveness of any hormonal contraceptives including implants and injectable options.**

**** combined oral contraception, progestogen only pill, progesterone only implant / injections and hormonal emergency contraception will be unreliable.**

GREEN- All drugs listed above are classified as green and maybe initiated in primary care, except where individually stated otherwise.

RED- Hospital Only Prescribing

A-Ret- Amber retained. Maybe prescribed in primary care but patient remains under the care of specialist (i.e. not discharged) as occasional specialist input may be required.