

Headache pathway (adults)

HC - hemicrania continua SAH – subarachnoid haemorrhage ICP - intracranial pressure TN – trigeminal neuralgia

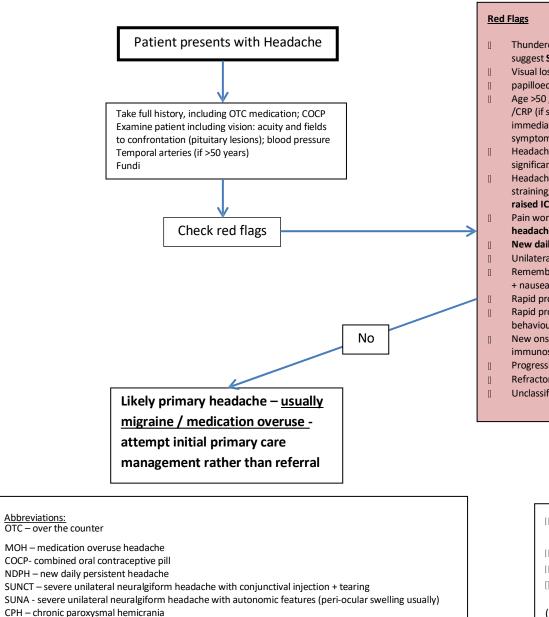


Key Points

- 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.



- 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
- 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)



Headache (adults) – primary care guidance



Migraine (usual cause of chronic headaches)

Migraine with Aura

Medication overuse

Tension type headache

Cluster headache

Others

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 which 8 migrainous

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 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

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

Affects M:F (3:1 ratio)

- Usually aged 20+ years
- Bouts last 6-12 weeks
- Usually occur 1-2x year
- Rarely chronic throughout
- 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



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



Migraine Acute therapy

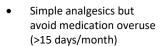
- Simple analgesia (aspirin, paracetamol, NSAID) or
- Simple analgesia + triptan if not effective or
- Simple analgesia + triptan + prokinetic antiemetic Triptan options- oral, orodispersible, nasal, injection Oral absorption can be unreliable in acute migraine Avoid COCP if any aura/ Severe migraine NO triptan DURING aura



- 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



- Treat any medication overuse
- Acupuncture- 10 sessions over 5-8 weeks if available
- Amitriptyline 10-75mg nocte-limited evidence of effectiveness (unlicensed)

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 dailyreduce 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

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

- Unilateral periorbital
- Autonomic (red eye, lacrimation, nasal congestion, ptosis
- 15-30 mins; 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/ hermicrainia continua/CPH:

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 (<u>SEE</u> 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 (<u>SEE</u> 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; <u>Valproate</u> 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 progestogenonly implant (IMP).

<u>Topiramate</u> 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.