Adult Headache Pathway

Patient presents with headache

- Do you have a headache all the time or does it come & go? (Tension Type Headache or Medicines Overuse Headache usually have pain all the time)
- If intermittent what do you do when you have the pain? (patients with migraine want to lie/sit still when pain is bad, those with cluster headaches can't sit still when having an attack)
- what tablets are you taking now and have you taken before?

Take history & examine including BP, temporal arteries (if age > 50years) & fundoscopy

Exclude red flags

Red Flags - Headache that is new or unexpected in an individual patient

- Thunderclap headache (intense headache of "explosive" onset suggest SAH)
- Jaw claudication (suggests temporal arteritis - take ESR /CRP & start steroids immediately)
- Headache with atypical aura (duration <30 minutes, or including significant/ prolonged motor weakness)
- Headache associated with postural change (bending) or coughing (possible raised ICP)
- New onset headache in patient with history of cancer, especially if < 20 years
- Remember carbon monoxide poisoning (also causes lethargy + nausea)
- Rapid progression of:
  1. sub-acute focal neurological deficit*
  2. unexplained cognitive impairment / behavioural disturbance*
  3. personality changes confirmed by witness where there is no reasonable explanation*
- New onset headache in a patient:
  1. with a history of HIV / immunosuppression*
  2. older than 50 years *
- Headache causing patients to wake from sleep*
- Progressive headache, worsening over weeks or longer*

Consider admission, urgent MRI scan (marked *) or 2ww referral as appropriate (direct access MRI not available in all CCGs)

Secondary headache - non serious cause

Posterior headaches may relate to cervicogenic headaches

Unlikely to be sinuses, TMJ dysfunction or teeth unless other signs /symptoms indicative of this

Consider medication – esp combined oral contraceptive pill (OCP). If patient has migraines with aura then HRT & oestrogen containing medicines are relatively contraindicated

If pain is paroxysmal consider facial pain trigeminal neuralgia as a cause of 'headache'

Primary headache

The major types are listed below – it is important to realise however that patients may have more than one type, so can develop tension type headaches on underlying migraine, or medication overuse with tension type headaches. If features of both migraine and tension-type headache, class as Migraine.
NICE recommends keeping a headache diary

Most people who attend their GP with recurrent / chronic headaches have migraine.

A recurrent severe headache associated with nausea and photophobia is 98% predictive of migraine

Migraine without aura

Diagnostic criteria - at least 5 attacks fulfilling criteria 1-4
1) Lasts 4-72 hours untreated
2) At least 2 of the following
   - Unilateral location
   - Pulsating quality
   - Moderate/severe pain
3) Nausea / vomiting and/or photophobia
4) No other cause identified

Chronic Migraine with or without aura not responding to an adequate treatment trial needs specialist review

Migraine with aura

Occurs in 1/3 of migraine sufferers
Aura 5-60 minutes prior to headache
Usually visual – note blurring & spots not diagnostic

Chronic Migraine with or without aura not responding to an adequate treatment trial needs specialist review

Tension type headache (TTH)

Usually episodic
Deemed chronic if >15days per month
Stress is common trigger but not always obvious

Can occur in combination with migraine and secondary headache triggers especially cervicogenic /neck problems

Medication Overuse Headache (MOH)

M:F (1:5 ratio)
Medication history is crucial especially use of over the counter analgesia

Can occur with other headache types
Prophylaxis medication doesn't help & can worsen

Cluster headache (Type of Trigeminal Autonomic Cephalalgias (TACS))

Affects M:F (3:1 ratio)
Usually aged 20+ years
Bouts last 6-12 weeks.
Usually occur 1-2x year, often at same time of year.
Rarely chronic throughout year.
Very severe – often at night & lasts 30-60 minutes
Strictly unilateral
Ipsilateral conjunctival injection, rhinorrhea +/- Ptosis confirm

Note: Referrals without an adequate trial of preventative treatments and appropriate withdrawal of analgesics may lead to referral not being accepted by the specialist team

Migraine with / without aura

Step 1- For acute attacks simple short term Over the Counter (OTC) analgesic & triptan – evidence suggest combination maybe best
- consider adding anti-emetic
- avoid opioids

Triptans – may need to try more than one type.
Care needed however as frequent use can lead to triptan overuse headaches (a form of MOH). Aim to use <2 doses/week.
Use most cost-effective first
Also note migraines often return 48-72 hours post use of a triptan

Step 2 - consider rectal analgesic (diclofenac) & anti-emetic suppositories (domperidone) if nausea & vomiting, but be aware of recent MHRA guidance

If headaches are frequent &/or acute medication is used very frequently, prophylaxis should be considered. This should be titrated until control is gained and may take 6-8 weeks before beneficial effects are seen. Usually needs to be continued for at least 6 months before considering a trial without

Prophylaxis – Trial each treatment at maximum tolerated dose for at least 4- 6 months before trialling an alternative
1st line Beta- blockers-propanolol 80-240mg in divided doses
Or
Amitriptyline before bed - initially small dose-10mg nocte, increasing to up to 150mg (NICE guidelines suggest poor evidence of efficacy)
Only use nortriptyline if amitriptyline effective but patient

2nd line Topiramate* - 25mg od to max 50mg bd
Note topiramate is an enzyme inducer so care is needed with combined OCP/POP. Can cause foetal abnormalities - contra-indicated in pregnancy & in women of childbearing potential not using effective methods of contraception.

If suspicious features in history or examination along with no response to treatment, consider value of MRI

Consider referral after 2 trials of prophylaxis

Tension Type headache (TTH)

Step 1 - Simple OTC analgesic (avoid opioids) e.g. ibuprofen along with explanation & reassurance. Look at triggers and consider medicine overuse headache (MOH)

Step 2 - consider alternative NSAID such as naproxen 500mg bd – maybe worthwhile taking regularly for a while if headaches are severe (with PPI cover if needed)

Step 3 - consider additional therapies e.g. acupuncture upto 6 sessions

Step 4 - if headaches severe, frequent & persist consider amitriptyline starting at low dose of 10mg at night, slowly increasing to 75-150mg
Note-B blockers not usually helpful & benzodiazepines should be avoided. SSRIs not helpful unless there is underlying depression
Can also consider TENS (patients should purchase) and cognitive therapies

Reconsider and exclude red flags again (see part 1). Also consider mixed headaches – Migraine & TTH and / or Medicine Overuse Headache

Consider whether MRI should be part of diagnostic process (where available)

NO - MRI not appropriate. Further advice needed about diagnosis or management

Yes and patient Accepts MRI scan

MRI SCAN

Normal MRI scan and patient reassured – continue with Rx – consider trials of higher dosages for longer periods

Abnormal MRI scan or patient not reassured despite normal MRI or need further advice

REFER

Cluster headache (TYPE OF TACS)

Most patients with new onset cluster headaches will require referral to a neurologist for advice.

Step 1- though short lived medication is nearly always needed (subcut sumatriptan is gold standard but consider intranasal triptan). Oxygen should only be prescribed if recommended by a neurologist.
Usually prophylaxis is the best option
Note- B blockers should not be used for cluster headaches

Step 2 - Prophylaxis dose should be increased rapidly; most sources suggest verapamil as first line
Prednisolone should be started at the same time as verapamil - 60-100mg daily for 5 days then decrease by 10mg every 3 days, so that treatment is discontinued after 2-3 weeks
Verapamil 80mg tds starting dose then increase dose in increments of 80mg every 2 weeks as prednisolone withdrawn (ECG done at baseline and following each increase in dose. At stable dose ECG should be done once eve

Remember - lifestyle measures may help

Medicine Overuse Headache (MOH)

- Only treatment is withdrawal.
- Education & communication is critical.
- Sometimes regular naproxen may be used in the early stages of withdrawal

Can occur on top of other types of headaches

Menstrual migraines can be identified via headache diary. May respond to hormonal Rx-see www.bash.org.uk

Care needed with pregnancy - these guidelines do not apply to pregnancy or children – see NICE & BASH guidelines at www.bash.org.uk

Don't forget patients often have more than one type of headache

Adult Headache Pathway

Self Help Resources

Patient UK – www.patient.co.uk

Migraine Action association http://www.migraine.org.uk/

Migraine Trust - http://www.migrainetrust.org/

Organization for the understanding of cluster headaches - http://www.ouchuk.org

NHS Choices http://www.nhs.uk/conditions/Headache/Pages/Introduction.aspx

Organisation for the Understanding of Cluster Headache – OUCH (UK)
https://ouchuk.org/history-ouchuk

References	▪ Headaches in over 12s: diagnosis and management NICE Clinical guideline [CG150] Published date: September 2012 Last updated: November 2015 https://www.nice.org.uk/guidance/cg150 ▪ The British Association for the Study of Headache (BASH) National headache management system for adults 2019 https://www.bash.org.uk/guidelines/ ▪ The International Headache Society https://www.ihs-headache.org/
Acknowledgements	Mid and South Essex CCGs Medicines Management Teams and Nottingham APC
Version	1.0
Author	HCPMSEMOC working group
Approved by	MSEMOC; MSE Joint Committee
Date Approved	December 2020
Review Date	December 2025 or sooner if subject to any new updates nationally