HEADACHE

Summary of British Association on the Study of Headaches {click to visit}

F:M=3:1
Affects 15% adults

- Primary:
  - Migraine (with aura 1/3, without aura 2/3)
  - Tension
  - Cluster
  - Other
- Secondary
- Neuralgia

History:

What type of headache [two types can coexist]
Episodic/daily/unremitting
etc

Migraine without aura:

5 of the following:

- At least 5 attacks fullfilling follow critera:
  - 4-72hrs [can be shorter in kids where GI symptoms and bilateral predom]
  - At least 2 of [unilateral,pulsating,moderate-severe,aggrav by/ causing avoid of physical activity]
  - Nausea/vomit
  - Photophobia/phonophobia
  - Not attrib to secondary

Aura 5-60 min prior: visual/numbness/dysphasia
¾ get presponse from triptan

Tension type headache

Mainly generalized. Not more than 7eral hours. Pressure/tightness. Commonly worse during the day
Chronic tension headache >15 days/month

Cluster [trigmeninal autonomic cephalagias]

UNILATERAL. Focus on one eye – can be over larger area
Similar time [often 2hr after going 2 sleep]. Lasts 30-60min
Signs: conjuct inject/lacrimination/rhinorrhoea/nasal congest/ptosis.
M:F=6:1.Age >20. Smokers
7eral attacks over 6-12 week every year or two.same time of year

Medication over use

1:50 adults. F:M=5:1
Most common with paracetamol,aspirin,NSAIDS. Less so with tryptans. Takes weeks to months to resolve after withdrawal

Beware:Ergot intoxication

risk great is take low dose daily rather than larger dose weekly
Worse in morning. Increase after physical exertion. Can have N+V. Prophylactic meds can make worse
Diary over 2 weeks [associated symptoms,medication use]

Differential

Cervicgenic [c spine]
Sinusitus
Refractive errors :NOT VERY COMMON.mild frontal in eyes themselves
Ears/TMJ/teeth [but should have symptom suggestive]

RED FLAGS:

- Thunderclap
- Atypical aurea (>1hr or including muscle weakness)
- Aura in first dose of CoC user
- New onset >50 [consider GCA] or <10
- Progressive [over weeks/months]
- Postural [raised ICP]
- Immunocompromised
- History of cancer

Examination

EXAMINE FUNDUS!!!
BP
Neck [tenderness,stiffness,limitation,crepitation espec in tension headache]
Kids: head circumference

SERIOUS CAUSE OF HEADACHE

Tumour	3 per million/year present with headache Symptoms of raised ICP [vomit/visual distrub] Epilepsy. LOC EXAMINE FUNDUS [repeat at followup] Suspect if immunocompromised/cancer
Meningitis	
Subarachoid	Severe, sudden onset. Neck stiffness develops a few hour later.Elderly often lack classical symptoms
Giant cell arteritis	Consider if >50 May not always have headache.

	Persistent.Often worse at night.Severe Only small number tender over temp artery THEY LOOK UNWELL Jaw claudication.Scalp tenderness ESR>50. Elderly often require biospy
Primary angle closure glaucoma	Risks: hypermetropia,female,FH Rare before middle age Unilateral painful red eye. Pupil mid dilated+fixed N+V. Impairsed vision Can be episode/mild – coloured haloes around light
Idiopathic intracranial hypertension	Risks:Young women. Obesity Hx not diagnostic but may have some feature of increased ICP MUST EXAMINE FUNDUS FOR PAPILLOEDEMA Will cause visual loss if undiagnosed
CO poisoning	Headache, N+V,giddineess,muscle weakness,dimness of vision/double visiion/fatigue Gas flames burn blue [shouldn't be yellow/orange]

MIGRAINES

Predisposing factors

- Stress
- Depression/anxiety
- Menstruation
- Menopause
- Head/neck trauma

Triggers:

- Relaxation after stress [weekend]
- Bright lights/noises
- Dietary: Alcohol/cheeses:not very common.headache needs to be within 6hrs of taking/reproducible/withdrawal leads to improvement

Treatment

Combine with rest and sleep [temazepam/zopiclone if need be]. Try each step 3 times before decide on treatment failure.

Step 1:

- a) Asprin 600-900mg or ibuprofen 400-500mg each upto QDS.Best taken early and in a soluble/orodispersable form
  N+V: Prochlorperazine 3-6mg bd buccal/domperidone 10mg QDS in 24hrs
- b) Aspirin 600-900mg, up to 4 doses in 24 hours /ibuprofen 400-600mg, up to 4 doses in 24 hours / diclofenac 50mg upto 200mg daily
  Combine with prokinetic:metoclopramide 10mg or domperidone 20mg
  [Migramax and paramax sachet ideal]
  [do not use aspirin if under 16. Metoclopramide not recommended for children/adolescents.prochlorperazine not recommended in children

Step 2:

Suppositories: diclofenac 100mg [200mg in 24hrs] + domperidone 30mg-60mg [upto 120mg in 24hrs].Limited use if have diarrhoea

Step 3:

Triptans:

Don't take too early [i.e. during the aura phase]. Take when headache is mild. Many respond to different triptan or via different route. 20-50% will have relapse with 48hrs. Administer with prokinetic [metoclopramide/domperidone].1/3 of patients do not respond to any triptan

Step 4:

Triptan +naproxen
then step 1+3.then step 2+3

Emergency for home visit:

Diclofenac 75mg IM [3ml in 2 different injection sites] +/- chlorprmazine 25-50mg IM as antiemetic/sedative

Management of relapse within same attack

Repeat Step 1 or 2

If using triptan. Dose could be repeated after 2hrs however caution: *repeated dosing can give rise to repeated rebound over several days.* Naproxen 500mg preferable

Avoid opiates/codeine etc [as cause gastric stasis/nausea]

Limits to acute therapy:
Over-frequent use of drugs for acute intervention may be one criterion for prophylaxis (see below).
On a regular basis:
a) use on **more than two days per week** is inappropriate for migraine [increase risk of MOH];
b) use on **more than one day per week** calls for close enquiry into how it is used, and review of the diagnosis.

PROPHYLAXIS

In overuse headache prophylactic drugs inappropriate until medication overuse stopped.
Dose titrate up [explain carefully otherwise patients will give up on it]
If *effective* should be continued for **4-6 months,**then withdrawal considered to establish continued need.Withdrawal - tapering dose over 2-3 weeks.
In absence of unacceptable side-effects, **6-8 weeks** trial following dose-titration

1st line
B blocker: Bisoprolol, atenolol, metoprolol, propranolol [best listed first]

Amitriptyline 10-150mg first-line when migraine coexists with:

- troublesome tension-type headache (see 6.7)
- another chronic pain condition;
- disturbed sleep
- depression

Side effects of dry mouth, sedation, dizziness and nausea often settle within first couple of weeks with continued use.

Pizotifen/clonidine no longer recommended

Menstrual migraine:
Migraine without aura that occurs regularly on day 1 of menstruation ± 2 days and at no other time. RARE. Confirm with diary card evidence over three months.

> **Mefenamic acid* 500mg tds-qds** can be given
> from the onset of menstruation until the last day of bleeding. Use *first-line in migraine occurring with menorrhagia and/or dysmenorrhoea.*
>
> ***frovatriptan* for 6 days (5mg bd on***
> **day 1; 2.5mg bd on days 2-6)** starting 2 days before expected onset of migraine.
>
> if intact uterus and is menstruating regularly, no progestogens necessary. **Transdermal estrogen*100µg *from 3 days before onset of menses for 7 days.*** Use 7-day patch. If effective but not tolerate use **50µg patch**. Alternatively, **estradiol 1.5mg in 2.5g gel** applied daily from **day -3 for 7 days.** The gel produces higher, more stable levels of estrogen and may be better.

Migraine in the pill-free interval:
Common in high-progestogen contraceptives- resolved by changing to more estrogen-dominant pill. As for menstrual migraine, can use oestrogen supplements during the seven-day pill free interval.

Tricycling: the CoC pill taken continuously for 9 weeks rather than 3 [5 withdrawal bleeds compared to 13]

Relative or absolute contraindications to ethinylestradiol
COCs:
a) Migraine with aura (experts disagree over whether an absolute contraindication).
b) Migraine treated with *ergot derivatives* but not triptans (relative).

Progestogen-only contraception is acceptable with any type of migraine contraindicating synthetic estrogens as its use is not associated with increased thrombotic risk.

Management Tension headache

Encourage regular exercise. Physiotherapy if neck problem. If due to stress lifestyle changes:relaxation/CBT/yoga/meditation

Drugs therapy
Use for episodic TTH occurring on fewer than 2 days per week.
(**aspirin 600-900mg[avoid if child<16], ibuprofen, 400mg). Paracetamol less effective.**

As the frequency of headaches increases, so does the risk of medication overuse. *Inappropriate* in chronic TTH, whether they appear to give short-term benefit or not [consider a one off trial of 3-week course of naproxen 250-500mg bd, taken regularly but if fails do not repeat.]

If above fails try amitripytline:
starting at a low dose (**10-25mg at night**). Increments of 10-25mg should be as soon as side-effects permit, perhaps each 1-2 weeks. Aim for dose range **75-150mg** at night. Attempt withdrawal after improvement has been maintained for 4-6 months.

Managing medication overuse headache

Emphasize "treatment" for headache is actually the cause.Use diary to record symptoms and medication use during withdrawal.
Use abrupt withdrawal.Encourage good hydration. Aggravation is expected over 3-7 days. The beginning of improvement follows, and occurs soonest (within 7-10 days) with triptan overuse, usually after 2-3 weeks with simple analgesic overuse, and after 2-4 weeks with opioid overuse.

Review after 2-3 weeks to ensure withdrawal has been achieved. Recovery continues slowly for weeks to months. Further followup is necessary. Most patients revert to their original headache type (migraine or tension-type headache) within 2 months. Overused medications (if appropriate) may be reintroduced after 2 months, with explicit restrictions on frequency of use.