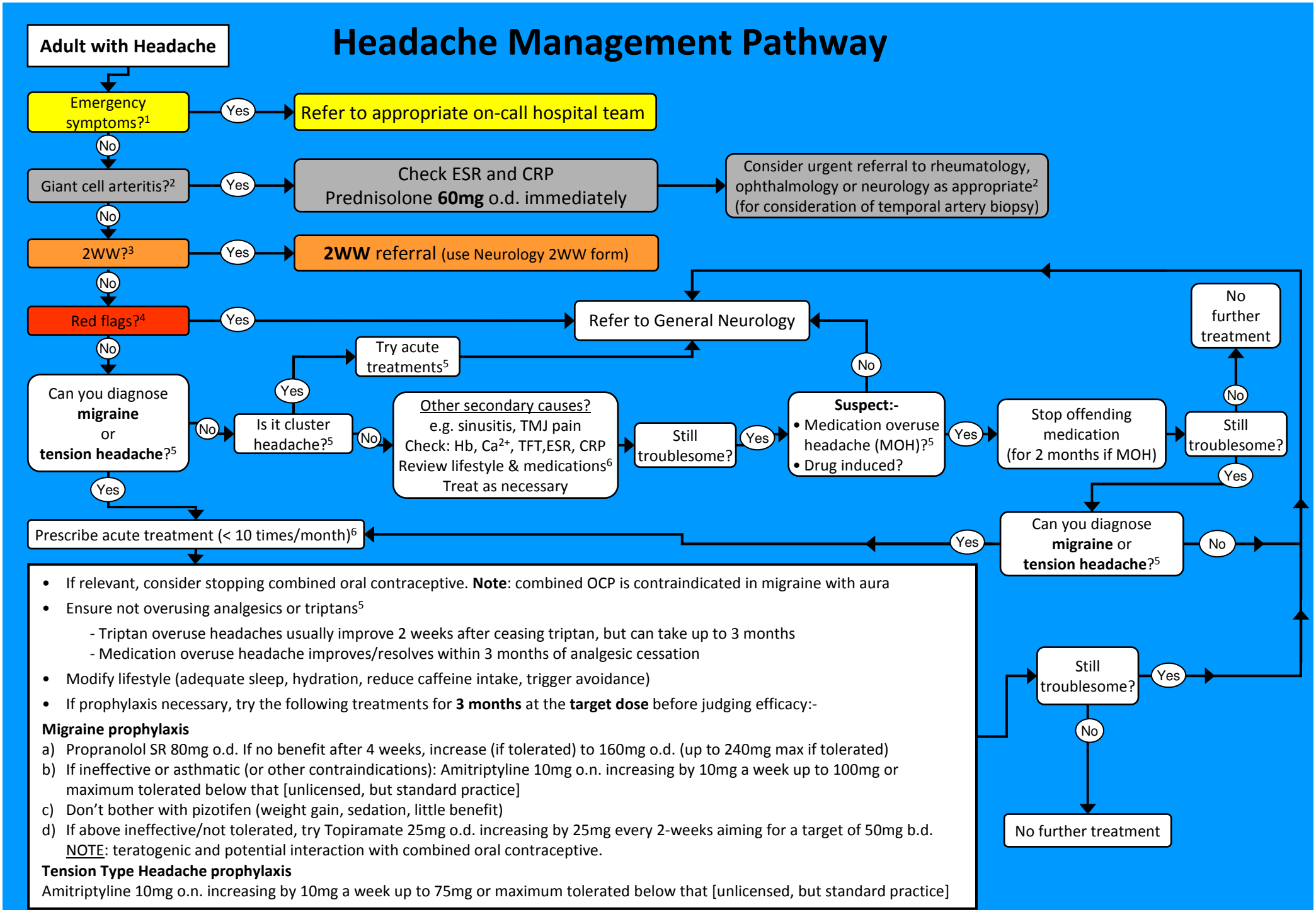
Headache Management Pathway



1)

Emergency Symptoms/signs

Thunderclap onset
Accelerated/Malignant hypertension
Acute onset with papilloedema
Acute onset with focal neurological signs
Head trauma with raised ICP headache
Photophobia + nuchal rigidity + fever +/-rash
Reduced consciousness
Acute red eye: ?acute angle closure glaucoma
New onset headache in:
- 3rd trimester pregnancy/early postpartum
- Significant head injury (esp. elderly/ alcoholics / on anticoagulants)

2)

Giant Cell arteritis (Incidence 2/10,000/ year)
- Think about it: New headache in >50 year old
- Many headaches respond to high dose steroids, so do not use response as the sole diagnostic factor.
- ESR can be normal in 10% (check CRP as well)
- Symptoms may include: jaw/tongue claudication, visual disturbance, temporal artery: prominent, tender, diminished pulse; other cranial nerve palsies, limb claudication

Urgent referral: rheumatology if diagnosis clear, neurology if 'headache ?GCA', ophthalmology if amaurosis fugax / visual loss / diplopia (not migrainous auras!).

3)

2WW (suspected cancer referral):
- **Headache with features of raised intracranial pressure:-**
  - Actively wakes a patient from sleep, but not migraine or cluster
  - **Precipitated** by valsalva manoeuvres (cough, straining at stool)
  - Papilloedema
  - Other symptoms of raised ICP headache include:-
    - Present upon waking and easing once up (MOH can cause this phenomenon) and worse recumbent
    - Whooshing pulsatile tinnitus
    - Episodes of transient visual loss when changing posture (e.g. upon standing)
- **Headache with new onset seizures**
- **Headache with persistent new or progressive neurological deficit**

4)

Red Flags
- Over 50 with a **new** headache whose onset was < 6 months ago
- Headache increasing in severity and frequency over the last 6 months despite appropriate treatment
- Undifferentiated headache (not migraine / tension headache) of recent origin and present for >8 weeks
- Recurrent headaches triggered by exertion
- New onset headache in:-
  - >50 years old (consider giant cell arteritis)
  - Immunosuppressed / HIV

5)

Tension Type Headache
Band-like ache
Featureless
Can have mild photo OR phonophobia OR mild nausea

Analgesic Overuse Headache
Can be migrainous and/or tension type
Analgesic intake:-
≥15 days/month
For ≥3 months
Any type of analgesic, opiates worse
Treatment: stop analgesic for 2 months

Triptan Overuse Headache
Can be migrainous and/or tension type
Triptan intake
≥10 days/month
For ≥3 months
Treatment: Stop triptan for 2 weeks - 2 months

Migraine (don't need a full house!)
Throbbing pain lasting hours – 3 days
Sensitivity to stimuli:
light and sound, sometimes smells
Exacerbated by physical activity
Aura (if present):-
- evolves slowly (in contrast to TIA/stroke)
- lasts minutes – 30min

Cluster Headache (Mostly men)
Most severe pain ever lasting 30-120 minutes
Unilateral
Agitation, pacing (cf migraineurs prefer to keep still)
Some Unilateral Cranial Autonomic features:-
tearing, red conjunctiva, ptosis, meiosis, nasal stuffiness

Acute treatments
Sumatriptan injection 6mg s.c. (contraindicated in IHD and stroke)
Hi-flow oxygen through a non-rebreath bag mask
Prednisolone 60mg o.d. for 1 week can abort a bout of attacks

6)

Top Tips in headache management

Most headaches are due to migraine (prevalence 10-15%!)
Caffeine overuse, stress, poor hydration, poor sleep hygiene etc can exacerbate headaches
Avoid opioids as predispose to medication overuse headache (more than other analgesics)
Use dispersible aspirin / NSAID +/- metoclopramide as first line analgesia
Avoid any analgesia including triptans on >2 days per week (excluding cluster headache)
Avoid combined oral contraceptive in migraine with aura