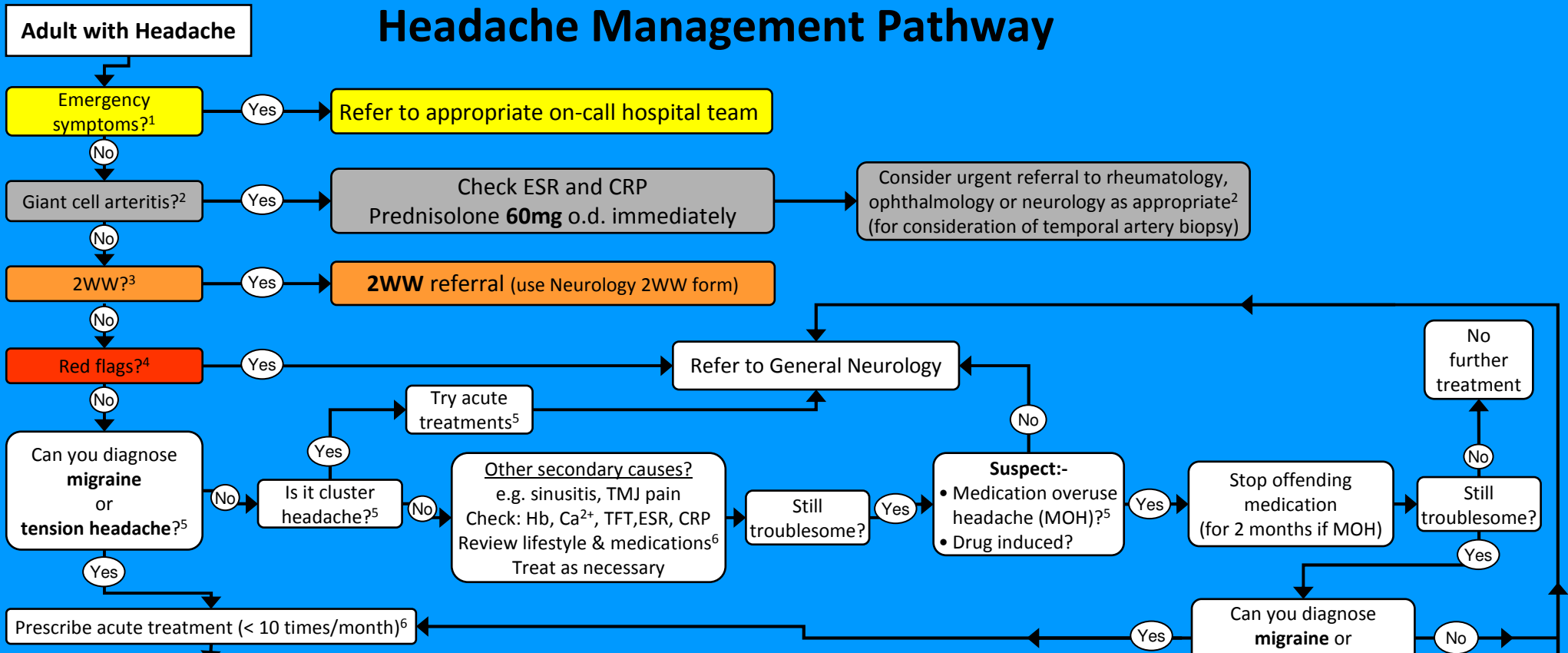


Headache Management Pathway



- If relevant, consider stopping combined oral contraceptive. **Note:** combined OCP is contraindicated in migraine with aura
- Ensure not overusing analgesics or triptans⁵
 - Triptan overuse headaches usually improve 2 weeks after ceasing triptan, but can take up to 3 months
 - Medication overuse headache improves/resolves within 3 months of analgesic cessation
- Modify lifestyle (adequate sleep, hydration, reduce caffeine intake, trigger avoidance)
- If prophylaxis necessary, try the following treatments for **3 months** at the **target dose** before judging efficacy:-

Migraine prophylaxis

- Propranolol SR 80mg o.d. If no benefit after 4 weeks, increase (if tolerated) to 160mg o.d. (up to 240mg max if tolerated)
- If ineffective or asthmatic (or other contraindications): Amitriptyline 10mg o.n. increasing by 10mg a week up to 100mg or maximum tolerated below that [unlicensed, but standard practice]
- Don't bother with pizotifen (weight gain, sedation, little benefit)
- If above ineffective/not tolerated, try Topiramate 25mg o.d. increasing by 25mg every 2-weeks aiming for a target of 50mg b.d.

NOTE: teratogenic and potential interaction with combined oral contraceptive.

Tension Type Headache prophylaxis

Amitriptyline 10mg o.n. increasing by 10mg a week up to 75mg or maximum tolerated below that [unlicensed, but standard practice]

- 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:-
 - o Present upon waking and easing once up (MOH can cause this phenomenon) and worse recumbent
 - o Whooshing pulsatile tinnitus
 - o 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

- 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

- 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

- 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

- 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

- 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