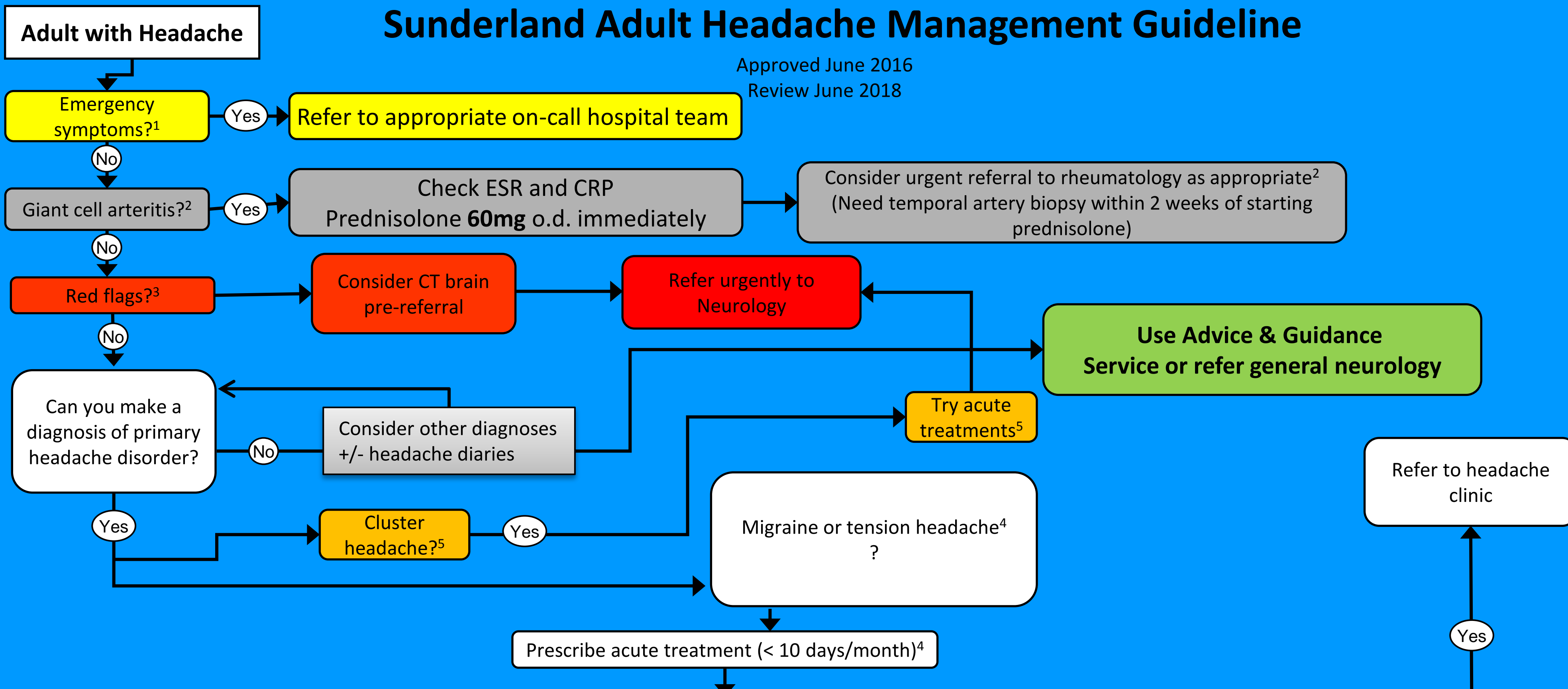
Sunderland Adult Headache Management Guideline

Approved June 2016
Review June 2018



- Encourage patient understanding: direct to www.migrainetrust.org ; supply with patient headache leaflets and diaries
- If relevant, consider stopping combined oral contraceptive. **Note**: combined OCP is contraindicated in migraine with aura
- **Ensure not overusing analgesics or triptans**[6]: Occurs if any of acutes being taken on average >2 days per week. Also similar effect from caffeine. Warn patient may get worse before get better (usually only for days). But may take up to 3 months for full reset.
- Lifestyle modifiers for headaches (regular sleep, fixed wake times, hydration, cut out caffeine, trigger avoidance, stress and anxiety management techniques, normalise BMI, daily aerobic exercise, monitor alcohol use). **Consider IAPT referral for anxiety.**

Consider prevention if >4/7 per month: try the following for **3 months at the highest tolerated target dose** before judging efficacy:-

a) Propranolol MR 80mg o.d. increasing gradually if tolerated to a maximum of 240mg a day;

b) If ineffective or contraindicated: Topiramate 25mg o.d. increasing by 25mg every fortnight aiming for a target of 50mg b.d. **NOTE**: teratogenic and potential interaction with oral contraceptives. Increasing in 15mg increments can enhance tolerability. Often causes paraesthesia (warn patients, not usually a reason to cease) and weight loss. Watch out for worsening depression.

c) Other options [*unlicensed, but standard practice*]: Amitriptyline 10mg nocte, titrated up to 50-70mg; if natural products preferred: riboflavin 400mg - patients source or acupuncture

Tension Type Headaches: Many believe part of migraine spectrum. Treat as such (often no treatment needed), but watch analgesic overuse.

Inadequate response to migraine preventatives. Is it chronic daily headache (>15/7 per month)?
Use headache diary

1)

Emergency Symptoms/signs
Thunderclap onset (i.e. max intensity in <5 mins)
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
- Other headaches may briefly 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 of classical GCA can include: jaw/tongue claudication, visual disturbance, temporal artery: prominent, tender, diminished pulse; other cranial nerve palsies, limb claudication

Urgent referral: rheumatology if GCA diagnosis suspected, ophthalmology or TIA clinic if amaurosis fugax / visual loss / diplopia (not migrainous auras!).

3)

Red Flags
- Headache rapidly increasing in severity and frequency despite appropriate treatment.
- Undifferentiated headache (not migraine / tension headache) or new persistent daily headache of recent origin and present for >8 weeks with focal neurological signs or high clinical suspicion of underlying structural cause.
- Recurrent headaches triggered by exertion
- New onset headache in:-
  - >50 years old (consider giant cell arteritis)
  - Patients with focal neurological signs or change in personality
  - Immunosuppressed / HIV

Patient in GP setting: Who to scan ?
Basically, no-one who does not need referring in needs a scan. However, if a scan is being done for reassurance, a CT head scan will suffice.

NICE (2013) *Headaches in young people and adults. Quality standard 42.* www.guidance.nice.org.uk/qs42

4)

Migraine at least 2 of the following features:
- Throbbing pain lasting hours - 3 days
- Unilateral
- Moderate to severe intensity
- Aggravated by physical activity (prefers to lie/sit still)

Plus any one of:
- Sensitivity to light and sound, sometimes smells
- Nausea

Aura (if present):-
- evolves slowly (in contrast to TIA/stroke)
- lasts minutes - 60min

'Chronic Migraine'
≥15 headache days/month of which ≥8 are migraine

Acute treatments:
Aspirin disp. 900mg or NSAID, taken with prochlorperazine
A triptan, but no more than 9 days per month (best <6/month)
Don't use opiates as they tend to lead to increase nausea and lead to an overuse headache
Poor absorption common in a headache attack – therefore better efficacy with anti-emetic, or non-oral (e.g. diclofenac supp, s/c or nasal triptan)

Tension Type Headache
Band-like ache
Mostly featureless
Can have mild photo OR phonophobia but NO nausea
Many believe this is simply a milder form of migraine (i.e. same biology and thus similar treatments can be effective)

5)

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

Acute treatments:
Sumatriptan injection 6mg s.c. or nasal spray (Contraind.: IHD and stroke)
Hi-flow oxygen through a non-rebreathe bag and mask (10-12litres/min) via HOOF form on ouchuk.com
Prednisolone 60mg o.d. for 1 week can abort a bout of attacks

6)

Analgesic/Triptan Overuse Headache
Often mixture migraine and background headache
Analgesic intake ≥15 days/month (opiates/triptans ≥10 days) for ≥3 consecutive months
Treatment: stop analgesic and triptan for 2 months and follow up