North West Headache Management Guideline for Adults – based on NICE CG150

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Adult with Headache

Emergency symptoms?[1] — Yes → Refer to appropriate on-call hospital team

No

Giant cell arteritis?[2] — Yes → Check ESR and CRP; Prednisolone 60mg od immediately → Consider urgent referral to rheumatology, ophthalmology or neurology as appropriate[2] (Need temporal artery biopsy within 2 weeks of starting prednisolone)

No

2WW?[3] — Yes → 2WW referral (use Neurology 2WW form)

No

Red flags?[4] — Yes → Refer to Headache Service OR Secondary care

No

Is it migraine or tension headache?[5]

Yes → Prescribe acute treatment (< 10 times/month)[5]

No → **Is it cluster headache?**[5]

Yes → Try acute treatments[5] → Refer to Headache Service OR Secondary care

No → **Other secondary causes?**
e.g. sinusitis, TMJ pain
Check: Hb, Ca^{2+}, TFT, ESR, CRP
Review lifestyle & medications[6]
Treat as necessary

Still troublesome?

Yes → **Suspect:-**
- Medication overuse headache (MOH)?[5]
- Drug induced?

Yes → Stop offending medication (for 2 months if MOH) → **Still troublesome?**

No → No further treatment

Yes → **Is it migraine or tension headache?**[5]

Yes → Prescribe acute treatment (< 10 times/month)[5]

No → Refer to Headache Service OR Secondary care

Education and better understanding of the condition can be facilitated by directing patients to NHS Choices: Headaches where a number of information leaflets can be accessed.

- If relevant, consider stopping combined oral contraceptive. **Note**: combined OCP is contraindicated in migraine with aura
- Ensure not overusing analgesics or triptans[5]
  - Triptan overuse headache usually improves 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, exercise, hydration, cut out caffeine, trigger avoidance, deal with psychosocial factors if possible)

Migraine prophylaxis: If necessary, try the following for **3 months at the highest tolerated target dose** before judging efficacy:-

a) Propranolol MR 80mg od increasing gradually if tolerated to a maximum of 240mg od

b) If propranolol ineffective or contraindicated then topiramate 25mg od increasing by 25mg every fortnight aiming for a target of 50mg bd. **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 at night increasing by 10mg a week up to 100mg at night or gabapentin 100mg tds increasing by 100mg tds to 900mg tds

Tension Type Headache prophylaxis: Amitriptyline as above. Acupuncture, if available.

Still troublesome?

a) Inadequate response to 3 migraine preventatives at maximally tolerated doses for 3 months each

and/or

b) Thinking about botulinum toxin treatment (see note 6)

and/or

c) Diagnostic doubt

Yes → Refer to Headache Service OR Secondary care

No → No further treatment

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 – especially elderly patients, alcohol dependency, people on anticoagulants

2) Giant Cell arteritis

Incidence 2/10,000 per year

- Consider with presentations of new headache in people >50 year old
- Many headaches respond to high dose steroids NB 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 to:

- Rheumatology if diagnosis clear
- Neurology if headache or possibly 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 i.e. cough, straining at stool
  - Papilloedema
  - Other symptoms of raised ICP headache including
    - Headache present upon waking and easing once up (analgesic overuse can cause this pattern) and worse when recumbent
    - Pulse synchronous tinnitus
    - Episodes of transient visual loss when changing posture e.g. upon standing
    - Vomiting - significance should be judged in context as nausea and vomiting are features of migraine
- **Headache with new onset seizures**
- **Headache with persistent new or progressive neurological deficit**

4) Red Flags

- Headache rapidly increasing in severity and frequency 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) Migraine

- Throbbing pain lasting hours - 3 days
- Sensitivity to stimuli: light and sound, sometimes smells
- Nausea
- Aggravated by physical activity (prefers to lie/sit still)

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

'Chronic Migraine'

≥15 headache days/month of which ≥8 are migraine

Acute treatments:

Aspirin dispersible 900mg or NSAID, taken with metoclopramide or domperidone NB Note MHRA warning
https://www.gov.uk/drug-safety-update/metoclopramide-risk-of-neurological-adverse-effects
https://www.gov.uk/drug-safety-update/domperidone-risks-of-cardiac-side-effects
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

Cluster Headache

More common in men
Most severe pain ever lasting 30-120 minutes
Unilateral, side-locked
Agitation, pacing NB migraineurs prefer to keep still
Unilateral Cranial Autonomic features:-
tearing, red conjunctiva, ptosis, miosis, nasal stuffiness

Acute treatments:

Sumatriptan injection 6mg s.c. - contra-indicated for IHD and stroke
Hi-flow oxygen through a non-rebreathe bag and mask
Prednisolone 60mg od 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 2-3 months

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

Analgesic Overuse Headache

Can be migrainous and/or tension type
Analgesic intake ≥15 days/month (opiates ≥10 days)
For ≥3 consecutive months
Treatment: stop analgesic for 3 months

6) Botulinum Toxin for Chronic Migraine: (NICE TA260)

Between 31 and 39 injections i.m. around scalp and neck every 12 weeks
Minimum treatment criteria:

- Chronic migraine i.e. ≥15 headache days/month of which ≥8 are migraine for a minimum of 3 consecutive months
- Tried 3 different migraine preventatives at maximally tolerated doses for 3 months each not including pizotifen
- Not overusing triptans, opiates or other analgesics