Primary Care Adult Headache Management Pathway
(formerly North West Headache Management Guideline for Adults)

Version 1.0

VERSION CONTROL		
Version	**Date**	**Amendments made**
Version 1.0	October 2018	Reformatted version 8 of the North West Headache Management Guideline for Adults to match other LMMG guidelines. Amended clinical content in line with NHSE OTC guidance.

Page

Adult Headache Management Pathway

Lancashire Medicines Management Group NHS

Adult with a headache*

Additional information on all headache types – page 2 and 3

Emergency symptoms? See page 2
- Yes → **Refer to appropriate on-call hospital team**
- No ↓

Giant cell arteritis? See page 2
- Yes → Check ESR and CRP; Give stat dose prednisolone 60mg and continue o.d. → **Consider urgent referral to rheumatology, ophthalmology or neurology as appropriate (need temporal artery biopsy within TWO weeks of starting prednisolone)**
- No ↓

2 week wait? See page 2
- Yes → 2WW referral (use neurology 2WW form)
- No ↓

Red flags? See page 2
- Yes → **Refer to headache service OR secondary care**
- No ↓

Is it a migraine or tension headache? See Page 3
- Yes → **For first or infrequent migraine:** Advise patient to purchase oral sumatriptan and an NSAID, OR oral sumatriptan and paracetamol. For people who prefer monotherapy consider oral sumatriptan, NSAID, paracetamol or dispersible aspirin 900mg. An anti- emetic e.g. buccal prochlorperazine may also be considered for purchase.

  For 'Chronic Migraine' ≥15 headache days / month of which ≥8 are migraine) see Box 1 and Page 3

  If unsuccessful → **Refer to headache service (where commissioned) OR secondary care to undertake clinical triage**
- No ↓

Is it 'cluster headache'? See page 3
- No ↓

Other secondary causes?
e.g. sinusitis, TMJ pain
Check: Hb, Calcium, TFT, ESR, CRP
Review lifestyle and medication
- No ↓

Suspect:
Medication overuse?
Drug induced? **See box 1 and page 3**
- No → **Refer to headache service (where commissioned) OR secondary care to undertake clinical triage**
- Yes ↓

Stop suspected medication for 1 month – see page 3
- If unsuccessful → **Is it a migraine or tension headache? See page 3**
  - No → **Refer to headache service (where commissioned) OR secondary care to undertake clinical triage**
  - Yes → **For first or infrequent migraine:** (see above)

*** Patients should be referred in accordance with local pathways, as appropriate**

Box 1 – Interventions

Migraine:

Education and better understanding of the condition can be facilitated by directing patients to NHS Choices: Headaches.

If relevant, consider stopping combined oral contraceptives (**note:** combined oral contraceptives are contraindicated in migraine with aura).

Ensure that the patient is not overusing analgesics or triptans:

- 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 once daily increasing gradually if tolerated to a maximum of 240mg once daily

b) If propranolol ineffective or contraindicated then topiramate 25mg once daily increasing by 25mg every fortnight, aiming for a target of 50mg twice daily.

Note: teratogenic and potential interaction with oral contraceptives. Often causes paraesthesia 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 three times daily increasing by 100mg three times daily to 900mg three times daily.

Tension type headache prophylaxis: amitriptyline as above. Acupuncture, if available

Adult Headache Management Pathway – additional information

Emergency symptoms or signs

Thunderclap onset
Accelerated or 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 or early postpartum
Significant head injury – especially elderly patients with alcohol dependency or patients on anti-coagulants

Red flags

Headache rapidly increasing in severity and frequency despite appropriate treatment

Undifferentiated headache (not migraine or 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 or HIV

Giant Cell Arteritis

Incidence 2/10,000 per year
Consider with presentations of new headache in people > 50years old
ESR can be normal in 10% - check CRP as well

Symptoms may include: jaw or tongue claudication, visual disturbance, temporal artery: prominent, tender, diminished pulse; other cranial nerve palsies, limb claudication

Many headaches respond to high dose steroids. **However,** do not use response as the sole diagnostic factor.

Tocilizumab for treating giant cell arteritis NICE TA 518: recommended as an option when used with a tapering course of glucocorticoids (and when used alone after glucocorticoids) in adults, only if:

1. they have relapsing or refractory disease
2. they have not already had tocilizumab
3. tocilizumab is stopped after 1 year of uninterrupted treatment at most and
4. the company provides it with the discount agreed in the patient access scheme

Urgent Referral to:
Rheumatology if diagnosis clear
Neurology if headache or possibly GCA
Ophthalmology if amaurosis fugax / visual loss / diplopia **NOT** migrainous auras

2 Week Wait – 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 e.g. 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. on 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

Adult Headache Management Pathway – additional information

Migraine

Throbbing pain lasting hours – 3 days
Sensitivity to stimuli: light and sound, sometimes smells
Nausea
Aggravated by physical activity (prefers to lie or sit still)
Aura, if present, that evolves slowly (in contrast to TIA or Stroke) and lasts minutes to hour.

Chronic Migraine (≥15 headache days per month of which ≥8 are migraine)

Combination therapy with an oral triptan and an NSAID, or an oral triptan and paracetamol. For people who prefer to take only one drug, consider monotherapy with an oral triptan, NSAID, aspirin dispersible (900 mg) or paracetamol.

Do **not** offer ergots or opioids for the acute treatment of migraine.

Consider an anti-emetic in addition to other acute treatment for migraine even in the absence of nausea and vomiting

Note: MHRA warnings for metoclopramide and domperidone (neurological and cardiac side effects respectively) – for details see MHRA alerts.
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

Cluster Headache

More common in men
Severe pain lasting 30-120 minutes
Unilateral, side locked
Agitation, pacing (note: migraine patients prefer to keep still)
Unilateral cranial autonomic features: tearing, red conjunctive, ptosis, miosis nasal stuffiness

Acute treatments:
Offer oxygen and/or a subcutaneous triptan (nasal triptan can be considered [unlicensed indication]).

When using oxygen for the acute treatment of cluster headache:
use 100% oxygen at a flow rate of at least 12 litres per minute with a non-rebreathing mask and a reservoir bag and arrange provision of home and ambulatory oxygen.

Do not offer paracetamol, NSAIDS, opioids, ergots or oral triptans

Tension Type Headache

Band like ache
Mostly featureless
Can have mild photo OR phonophobia but NO nausea

Treatment:
Aspirin, paracetamol or an NSAID

Do **not** offer opioids

Analgesic Overuse Headache

Can be migrainous and / or tension type
Analgesic intake ≥15 days per month (opiates ≥ 10 days) for ≥ 3 months

Treatment: Stop analgesic for 3 months

Triptan Overuse Headache

Can be migrainous and / or tension type
Triptan intake ≥ 10days per month for ≥ 3 months

Treatment: Stop triptan for 2-3 months

BIBLIOGRAPHY

1. NHS North West Coast Strategic Clinical Network. North West Headache Management Guideline for Adults, Version 8. September 2015.
2. National Institute for Health and Care Excellence. NICE clinical guideline 150: Headaches in over 12s: diagnosis and management. Manchester, 2012 (updated 2015).

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