ADULT HEADACHE GUIDELINES

HEADACHE TYPES:	**MIGRAINES:** ***Easily diagnosed with history (up to 99%)*** **MIGRAINES WITHOUT AURA:** Lasting 4-72hrs, usually unilateral, pulsating, moderate to severe intensity, aggravated by normal physical activity, associated with nausea, vomiting, photophobia or phonophobia, fatigue/energy drain/lethary (5 OR MORE ATTACKS TO CONFIRM DIAGNOSIS). **MIGRAINES WITH AURA:** Progressive, aura last 5-60 minutes prior to headaches Typical Aura: homonymous visual disturbance, unilateral parasthesia/numbness, unilateral weakness(now in the hemiplegic migraine group), dysphagia, a combination of above. (2 OR MORE ATTACKS TO CONFIRM DIAGNOSIS) *Trigger factors:* stress, certain foods, missing meals, too much or too little sleep, bright lights, loud noise, hormonal changes. Try reducing caffeine intake, particularly in the afternoon/evening to avoid sleep impairment. **TENSION TYPE HEADACHES:** Episodic or chronic, pressing or tightening and non pulsating, mild to moderate intensity, bilateral, not worse with activities, episodic lasting 30 minutes to 7 days **CLUSTER:** intense pain, unilateral, involving eye and frontal region, every other day to 8 times in 24 hours, can last 15-180 minutes. Associated symptoms: lacrimation, nasal congestion, rhinorrhoea, forehead/facial sweating, ptosis/miosis, eyelid oedema, restlessness/agitation during the attack. Bouts(untreated) lasting from 7 days to 12 months separated by pain-free intervals lasting at least 3 months. **HEADACHE WITH RAISED CSF PRESSURE:** Initially intermittent and then constant, pain is worse in a morning, and person may be woken by it. Headaches worse with change in posture, coughing, sneezing, straining or vomiting. **TRIGEMINAL NEURALGIA:** Usually face, unilateral, characterized by lancinating pains limited to the distribution of one or more branches of trigeminal nerve(usually 2nd and/or 3rd). Pain is paroxysmal, lasting from 2 seconds to 2 minutes. Described as intense, sharp, superficial, stabbing, burning or like an electrical shock. Between paroxysms the person is asymptomatic. Pain is usually triggered by innocuous stimuli in the trigeminal nerve territory (e.g. touch, cold) **MEDICATION OVERUSE HEADACHES (MOH):** Associated with Opioids, aspirin, paracetamol, NSAIDS, triptans and ergotamine. Regular intake of NSAID>15 days a month or codeine-containing Rxs >10 days a month Often worse on waking and increase after physical exertion Pre-emptive use of Rx in anticipation of rather than for headache Diagnosis based on symptoms and drug use and confirmed only when symptoms improve after Rx withdrawn. (The best management of medication overuse headache is not quite clear. Many people take the analgesia for other pains. Although removal of the offending agent is generally recommended it should not necessarily delay the treatment of the underlying headache disorder. MOH can look very much like the headache that the analgesics are taken for)
RED FLAG SYMPTOMS	Maximum intensity within 5 minutes of onset. (should prompt referral to A&E ? subarachnoid haemorrhage) New onset headache in a patient with a history of cancer Worsening headache with fever Progressive headache worsening over weeks or longer Compromised immunity (HIV infection , immunocompromising drugs) Headache with atypical aura (duration >1 hour, or including motor weakness) Aura occurring for the first time in a patient during use of combined oral contraceptives Headache associated with postural change New onset neurological deficit , cognitive deficit or personality change Head trauma in past three months

	Impaired level of consciousness Triggered by cough, valsalva, sneeze or exercise Vomiting without other obvious cause Substantial change in the characteristics of headache Features of giant cell arteritis or acute narrow angle glaucoma
ASSESSMENT EXAMINATION	Neurological Examination including tone, weakness, reflexes plantars, fundoscopy, BP, meningeal irritation and palpation of face and neck, including temporal arteritis. 3 minute neurological examination for GPs Link: http://www.gp-training.net/training/tutorials/clinical/neurology/neuro.htm **Counselling:** Alcohol, tobacco, drugs, medications, relaxation, education, safety netting
INVESTIGATIONS	Most people don't need any further investigations. ESR, CRP and possible temporal artery biopsy if suspected temporal arteritis. Do not refer people diagnosed with tension-type headache, migraine, cluster headache or medication overuse headache for neuroimaging solely for reassurance. **GP's have direct access to CT scan at TRFT** if required
TREATMENT:	**A. Migraine:** **"**Try and try again"- increasing doses of migraine prophylaxis RX. In cases of suspected primary headaches: Use a headache diary for a minimum of 8 weeks documenting frequency, duration and severity of headaches, associated symptoms, medications taken to relieve headaches, Precipitants and relationship of headaches to menstruation. **Acute Rx**: 1st Line: NSAID/Asporin/Paracetamol + Sumatriptan 2nd line: 1st line + Non-oral metoclopramide or prochlorperazine 3rd line: Non-oral Paracetamol, triptan metoclopramide or prochlorperazine. **Prophylaxis**: *1st line* Beta blockers, Topiramate *2nd line* 10 sessions of acupuncture 3rd line Riboflavin 400 mg once a day(unlicensed) Gabapentin (up to 1200mg per day)
	B. Tension-type headaches: *1st line* Aspirin, Paracetamol, NSAIDs * No Opiods Prophylaxis: Up to 10 sessions of acupuncture over 5–8 weeks **NB: Cluster headaches:** Avoid alcohol/nitrates, Triptans (Sumatriptan s.c. 1st choice). 100% oxygen. Consider referral. **Prophylaxis**: *1st line* Verapamil *2nd line:* Topiramate or valporate
	C. Medication overuse headaches: TREATMENT IS WITHDRAWAL OF ANALGESICS NSAIDs, Ergots, triptans and non opioIds can be stopped abruptly Can lead to withdrawal headache lasting 2-10 days (average 3.5 days) Consider Prophylaxis for the underlying primary headache Opioids/barbiturates need to be withdrawn slowly and may need inpatient stay
	D. Trigeminal Neuralgia: *1st line:* Carbamazepine 100mg-200mg BD increasing slowly to 1.2gm/day or Oxcarbazepine 300mg BD, titration in 300mg increments up to 1.8g/day in divided doses *2nd line:* Lamotrigine : Initial dose 25 mg OD, increasing gradually (weekly) to a maintenance dose of 200-400 mg/d in 2 divided doses. *3rd line:* Phenytoin 100mg OD slowly increasing to 200mg od *4th line:* Sodium valproate: try 200mg BD increasing to 2.4gm
	References: Prodigy - BASH Guidelines 2010 - Sheffield Guidelines

	NICE Guidelines http://www.guidance.nice.org.uk/cg150
Consultant:	Dr R Lindert, Consultant Neurologist, General Medicines, Rotherham Foundation Trust DR Price, Consultant Neurologist, Royal Hallamshire Hospital, Sheffield
Lead GP	Dr Phil Birks, RCCG GP
Date Approved:	January 2020
Review Date:	January 2022