Headache pathway (adults)

NHS
Pan Mersey
Area Prescribing Committee

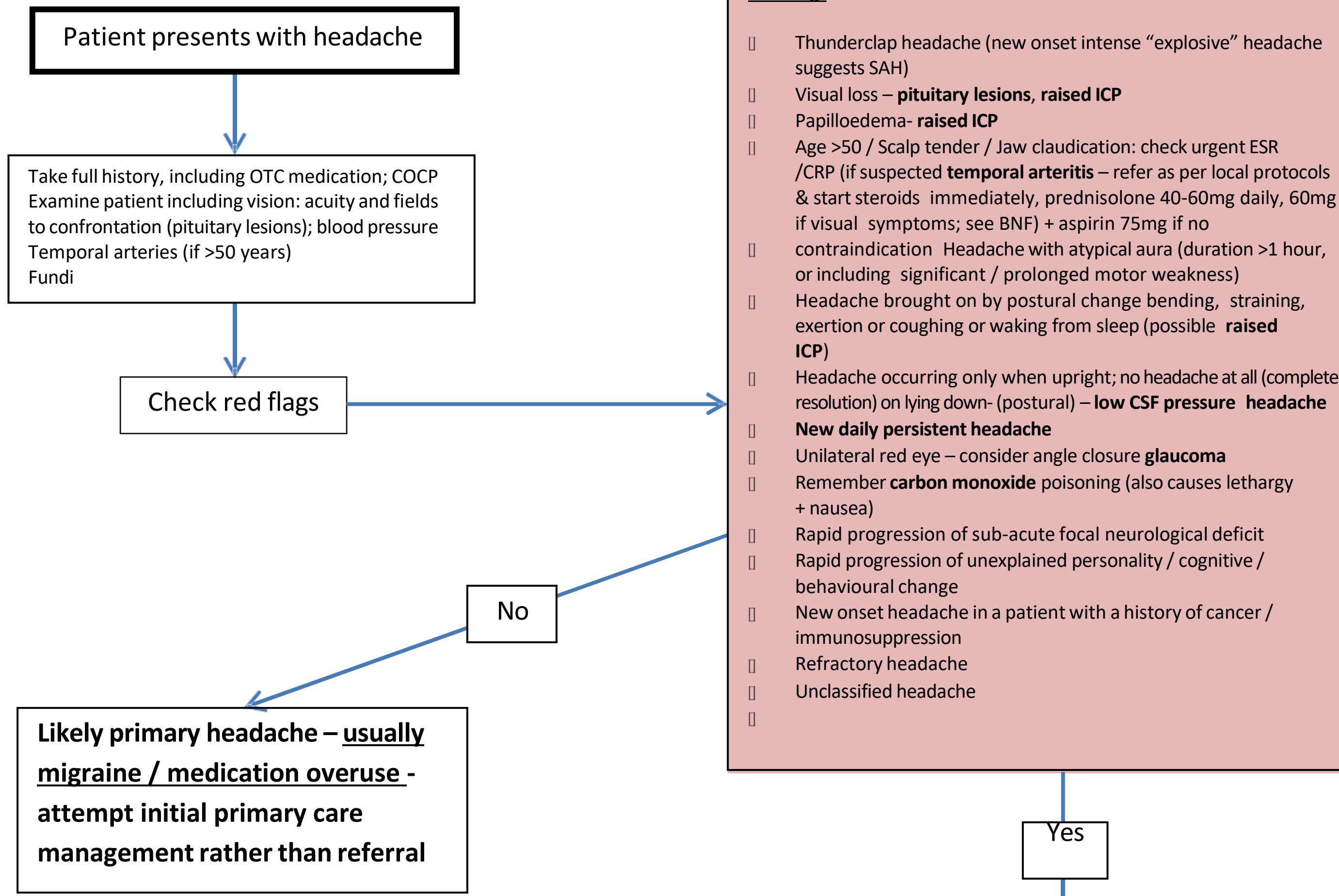
Key Points

- Most headache is migraine (intermittent or chronic) – probably up to 90%
- Stress, sinuses, eyesight are not usually causes of headaches
- MOH is common – and underdiagnosed; if suspected stop analgesics and caffeine intake
- Review medication (COCP in migraine, medication overuse headache - MOH)
- Consider age of patient (>50) – temporal arteritis
- Ask about activity in attacks – rest in migraine, restless in cluster headache
- Ask about duration – continuous, intermittent, paroxysmal
- If continuous – was it intermittent first or continuous from onset (new daily persistent headache – NDPH)
- NB – NDPH is usually recent and continuous (see red flags)
- Chronic migraine is usually longstanding and continuous – and previously intermittent
- Trigeminal neuralgia is paroxysmal
- Tailor medication to diagnosis
- Do not use opioids in headaches
- Few headaches respond to regular analgesics or triptans

Refer:

- **Cases with red flags (see opposite)**
- **New daily persistent**
- **headacheTrigeminal neuralgia**
- **SUNCT/SUNA**
- **Cluster headache**

- **HC / CPH**
- **Refractory / chronic migraine**
- **Unclassifiable, atypical headache or failure to respond to standard migraine therapies**



Abbreviations:
OTC – over the counter
MOH – medication overuse headache
COCP- combined oral contraceptive pill NDPH – new daily persistent headache
SUNCT – severe unilateral neuralgiform headache with conjunctival injection + tearing
SUNA - severe unilateral neuralgiform headache with autonomic features (peri-ocular swelling usually)
CPH – chronic paroxysmal hemicrania
HC - hemicrania continua
SAH – subarachnoid heamorrhage
ICP – intracranial pressure
TN – trigeminal neuralgia

- Walton Centre advice line: Weekdays 11.30-1.30 (07860 481429)
- Open access MR scan if available
- Refer
- Admit

(As clinically appropriate)

PAN MERSEY APC

Headache (adults) – primary care guidance

NHS Pan Mersey Area Prescribing Committee

Migraine (Commonest cause of headaches)

Diagnosis-at least 5 attacks fulfilling these criteria:

Last 4-72 hours if untreated

At least 2 of the following;

- Unilateral location
- Pulsating quality
- Moderate/severe pain
- Nausea/vomiting
- Photophobia &/or phonophobia
- No other cause identified

Other commonly associated features are fatigue, dizziness, cognitive & mood difficulties, insomnia, paraesthesia, visual blurring, slurring of speech

Chronic Migraine: >15 headache days per month, 8 of which severe

Migraine with Aura

Occurs only in 1/3 of migraine patients

Symptoms of aura gradually develops over a few minutes and can last for up to an hour

Usually visual-- blurring & blackspots are not diagnostic

Can be speech/ motor/ sensory

Full recovery after attacks

Migraine Acute therapy (must be taken at onset of an attack) (Max permitted up to 2 days per week)

Triptan, Aspirin, Paracetamol, NSAID- On their own or combining a triptan with one of the others. If using combined therapy, take both medications together at

Triptan options- oral, orodispersible, nasal, injection

Oral absorption can be unreliable in acute migraine- hence antiemetics are useful.

Avoid COCP if any aura/ Severe migraine

NO triptan DURING aura

Medication overuse

Medication history is crucial, especially use of over-the-counter analgesia.

- Overuse: Triptans/opioids >10 days a month for >3 months
- Overuse: Simple analgesics >15 days a month for >3 months
- Usually with underlying migraine
- Usual acute migraine therapy ineffective

- Withdraw analgesics and caffeine
- Prn ibuprofen/naproxen up to 2 days per week
- Consider low dose amitriptyline 10-75mg nocte (unlicensed)
- Manage underlying headache disorder with suitable preventatives (Migraine in majority)

Headaches could worsen for 6-8 weeks (especially if stopping opioids)

Tension type headache

Usually episodic, can be chronic

Chronic if >15 days per month

Featureless, bilateral, mild, or moderate intensity

Does not limit or impact daily activity

Can occur in combination with migraine

- Simple analgesics but avoid medication overuse(see med overuse section)
- Treat any medication overuse
- Acupuncture- 10 sessions over 5-8 weeks if available
- Amitriptyline 10-75mg nocte- limited evidence of effectiveness (unlicensed)

Cluster headache

Affects M:F (3:1 ratio)

- Usually, aged 20+ years
- Bouts last 6-12 weeks
- Usually occur 1-2x year
- Rarely chronic throughout year
- Very severe- often at night & lasts 20-60 mins- rarely up to 4 hours
- Restless, agitated
- Often triggered by alcohol
- Unilateral, periorbital
- Ipsilateral autonomic features with conjunctival injection, rhinorrhea, nasal congestion, ptosis, ear fullness, flushing

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Acutely

- Nasal or sc sumatriptan prn (3mg up to QDS, or 6mg up to twice a day if needed)
- 100% oxygen 15L/min

Termination of cluster

- Prednisolone 60mg daily- reduce by 10mg every 3 days
- Verapamil 80mg tds increased to 120mg tds if needed (may need 240 mg tds or more; start at same time as steroids)
- ECG initially, after dose increases and weekly if >120 tds (hospital if not possible in primary care)
- Refer all cluster cases for specialist review + MRI

Others

Trigeminal neuralgia

- Triggered unilateral facial pain
- Sudden paroxysmal
- Not continuous
- Triggered- breeze, chewing, talking

SUNCT/SUNA

- Similar to TN (but frontal area)
- Autonomic ocular features

Ice pick/ Stabbing

- Sudden brief head pains
- Various locations
- Commonly associated with migraine

Chronic Paroxysmal Hemicrania

- Unilateral periorbital
- Autonomic- red eye, lacrimation, nasal congestion, ptosis
- 15-30 mins; multiple/day

Hemicrania Continua (HC)

- Unilateral 'side locked' constant headache
- >3 month
- Autonomic features
- Restlessness

TN: carbamazepine 100-200mg daily; gradually increased to effect; lamotrigine (unlicensed) or phenytoin if allergic to carbamazepine

SUNCT/SUNA: Lamotrigine increased to 200mg BD (unlicensed).

Ice-pick/ hemicrania continua/CPH: Indometacin 25-50mg tds (unlicensed) with PPI cover

Headache (adults) – primary care guidance

Migraine – Prophylactic therapy options (try for 3 months):

- Stop caffeine intake, reduce analgesia use to 2 days per week
- **Propranolol -** 80-240mg daily
- **Topiramate - 25mg od 2 weeks; 25mg bd 2 weeks; then 50mg bd which can be increased further as required up to 100mg BD; see adjacent warning for females of childbearing potential. Stop if cognitive or mood disturbance occurs**
- **Candesartan -** 8-16mg daily
- **Amitriptyline -** 10-75mg **(nortriptyline if better tolerated). Avoid if poor quality sleep or restless legs syndrome.**
- **Acupuncture if available**
- **Sodium valproate -** up to 1600mg daily; not in women of childbearing potential
- **Cefaly device (available from BHR)**
- **GammaCore device (available from Electrocore)**

The preventative medication dose should be escalated up until the best & maximum fully tolerated dose is reached. As a practical rule start at a low dose and gradually increase the dose aiming for the midpoint of the therapeutic dose range. Then the drug should be continued for at least 2- 3 months to assess benefit, using headache diaries to monitor. If the medication is not beneficial it should be tapered off and the same strategy applied for the next preventive medication.
If the medication is found to be effective – it should be continued for a further 6-9 months. Provided the patient's symptoms remain well controlled, an attempt can be made to withdraw and stop the medication at that stage. If symptoms recur, consider restarting the medication.

In refractory cases who have failed at least 3 preventatives and medication/caffeine overuse have been eliminated - please ask patients to maintain headache diaries (The Walton Centre website > Departments and Services > Headache Service > Files: headache diary) and refer for consideration of:

- **Botulinum toxin (Chronic migraine only- see above)**
- **CGRP monoclonal antibodies**

Please note & inform patients there may be a waiting list for these treatments.

The Walton Centre website > Departments and Services > Headache Service > Patient Leaflets > Migraine - a comprehensive guide.

NB:

Valproate medicines must NOT be used in any women of childbearing potential

Topiramate is contraindicated in pregnancy. Highly effective contraception is required prior to initiation and during treatment*. A pregnancy test should be performed before initiation of treatment. Advise women and girls of childbearing potential that topiramate is associated with a risk of foetal malformations and can impair the effectiveness of hormonal contraceptives.

***Acceptable contraception options include the coil (copper or Mirena), or the contraceptive injection plus condoms.**

GREEN- May be initiated in primary care, except where individually stated otherwise.

AMBER- Privately funded treatments, can be purchased directly by patients.

RED- Hospital only prescribing.