NCL CCG is aware this pathway needs a review. When the expiry date passes, please use with discretion until an update is available.

Adult Headache Primary Care Protocol

Version 5: February 2019
Review Date: April 2020

Lifestyle advice popup

Make every contact count:

Smoking status = smoker?
Alcohol consumption = >14 units/wk ♀♂
BMI / physical inactivity / diet = BMI ≥30, <150 mins PA/wk

Mental Health = drugs and alcohol

Mental wellbeing = Signs of stress / anxiety

Monitor lifestyle triggers such as:
- Tiredness, Periods, Stress, Dehydration, Hunger, Changes to routine

Key
- "Must do" actions for GP's / (Triaged by RMS)
- Recommendations for Primary Care
- Red flag / urgent referral
- Routine referral
- Public health intervention
- Audio-visual aids for patients and GP
- Click icon for clinical evidence

Patient presents with headache

RED FLAGS
- Sudden onset worst ever headache
- Systemically unwell – fever, meningism, rash, BP >180/110
- Focal neurological signs or altered mental state
- Suspected giant cell arteritis
- Red eye/blurred vision (suspected acute angle closure glaucoma)

Same day on-call referral

SUSPECTED SPACE OCCUPYING LESION– signs of raised intracranial pressure (ICP) especially seizures, focal neurology, persistent unexplained vomiting.

See appendix 1 for further details.

Refer 2ww/discuss with on-call neurologist depending on presentation.
Ref: NG12 [updated July 2017]

- New/altered headache with underlying malignancy or immunosuppression
- Pregnancy plus new headache/visual disturbance
- New onset of progressively worsening headache >50 years
- Atypical features e.g. hemiplegia/focal neurology/restlessness/vasomotor symptoms, aura >60min.

Urgent referral to **appropriate** specialty

All other headaches

EPISODIC HEADACHES
Acute episodes <50% of days

Migraine
- Recurrent episodes
- Moderate to severe
- Pulsatile, exacerbated by movement or exertion
- Associated with nausea, vomiting, light or noise intolerance.
- Triggers (see lifestyle box)
- **Stop COCP with aura or >35 years**

Tension-type
Episodes last 30min→7days with either bilateral location, pressing or tightening, mild or moderate intensity and not aggravated by routine physical activity such as walking or climbing stairs.

Cluster Headache
- Always unilateral
- VERY severe orbital/ supraorbital/ temporal
- Can get autonomic features, eg. Lacrimation or conjunctival injection, eyelid swelling or droop, nasal congestion or rhinorrhoea
- Alternate days up to 8 times a day

Suspected new diagnosis

If red flags or clinical concerns, please seek advice from on-call neurologist

Trigeminal Neuralgia
Severe, lancinating, electric-shock pain triggered by touching/washing/shaving and cold air.
SEE PAGE 2 FOR ROUTINE MANAGEMENT

Depending on clinical scenario, discuss with on-call neurologist
See Appendix 2 for possible scenarios.

Lifestyle Changes
20% settle by reducing triggers (e.g. stress, improving sleep)
Predisposing factors
Stress, depression or anxiety, menstruation, menopause, head or neck trauma.

Acute treatment of headache attack:
Take medication as early as possible.
Triptan (e.g. Sumatriptan 50mg PO) plus NSAID (e.g. Aspirin 900mg or Ibuprofen 400mg) plus anti-emetic (eg.Metoclopramide 10mg max 5/7)
PATIENT CAN TAKE ALL OF THESE TOGETHER
Referral Criteria: GP will need to have tried at least one drug from acute management consider paracetamol where NSAID is contraindicated

If frequent or disabling ACUTE migraine, consider prevention:
1. Beta Blocker e.g. Propranolol 80 - 240mg/24º or metoprolol 25mg od- 200mg/24º
2. TCA's e.g. Amitriptyline 10mg 1 hour before bed, increase fortnightly to max 50-150mg; Nortriptylene if too sedating
3. Topiramate** - 25mg on, increase by 25 mg weekly to 50mg bd (associated with teratogenicity risk and can potentially impair the effectiveness of oral hormonal contraceptives
4. Candesartan 16mg/day

SEE PAGE 2 FOR CHRONIC HEADACHE

If no better after 3 consecutive doses of triptans see further management (next page) or if clinical concerns

Seek A&G via e-RS

If unsure

Management of Cluster Headaches
Terminating an individual attack:
- Sumatriptan 6mg s/c, self- administered by patient into thigh. (Medication overuse problems are uncommon so do not restrict frequency.) or can consider nasal triptans

SEE PAGE 2 FOR CHRONIC CLUSTER HEADACHES

Refer to Neurology

Chronic Daily Headache
Headaches >50% of days for ≥3 months

SEE PAGE 2 TO FOLLOW

REMINDER:
if isolated new acute/subacute onset, persistent daily headache without cause or improvement <12 weeks
See appendix 3.

If headache not settling or other clinical concerns, please consider MRI Brain (if meets referral criteria) and/or Urgent Neurology Referral

OR

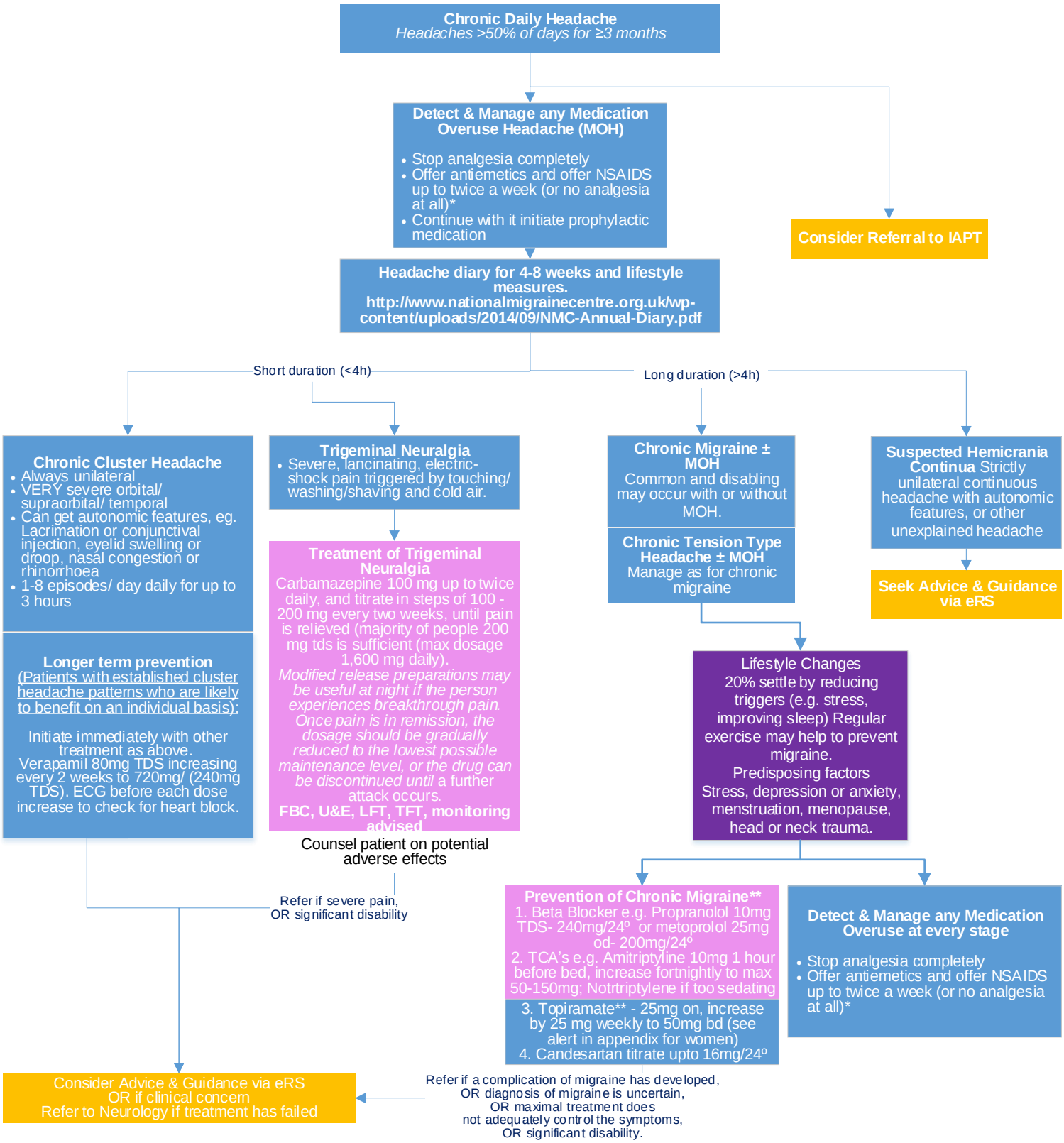
contact the telephone helpline between Monday – Friday 11am – 1pm on telephone number (coming soon)

APPENDIX 1

Key features to discern likely neoplasm:
1. Is there any progressive loss of neurological function, e.g.. hemiparesis/ hemianopia/ ataxia or dysphagia?
2. Is there a new onset of seizures, especially focal seizures?
3. Are there any symptoms or signs of systemic unwellness to suggest a possible underlying malignancy, such as lethargy, weight loss and clubbing?

If any one of the above are present, this should lead to a 2ww. If none of these features are present, but the GP still suspects a space-occupying lesion or raised intracranial pressure, they should refer to neurology advice and guidance first.

APPENDIX 2
Any of the following features should lead to discussion with on-call neurologist: sensory changes, deafness or ear problems, skin or oral lesions, optic neuritis, pain only in V1 of the trigeminal nerve, a family history of MS or age under 40 years OR if patient is systemically unwell.



DVLA states that people with 'liability to sudden and unprovoked or unprecipitated episodes of disabling dizziness' should stop driving and inform the DVLA

APPENDIX 3
https://www.healthylondon.org/wp-content/uploads/2017/11/Pan-London-Suspected-Cancer-Referral-Guide-Brain-and-CNS.pdf

***Suspected medication overuse with:**
Ergotamines, triptans or opioids > 10 days/ month; simple analgesia > 15 days/ month for > 3 months
Consider MOH at every stage
****Drug contraindications**
Topiramate: Advise women and girls of childbearing potential that topiramate is associated with risk of fetal malformations and can impair the effectiveness of hormonal contraceptives. There is an increased risk of metabolic acidosis in patients with hepatic or renal impairment or diarrhoea.
BetaBlockers: Avoid betablockers in asthma, depression, diabetes, COPD, peripheral vascular disease, or uncontrolled heart failure.
Candesartan: Avoid in renal impairment and type 2 diabetes.
Amitriptyline: Avoid in people who have had recent MI or who have arrythmia. It should be used with caution in people with ischaemic heart disease or epilepsy. Common adverse effects include constipation, weight gain, dry mouth, sedation, nausea, and dizziness. These are usually apparent in the first couple of weeks of taking the drug and settle with continued use.