

Headache pathway (adults) - Primary Care Guidance

Key Points

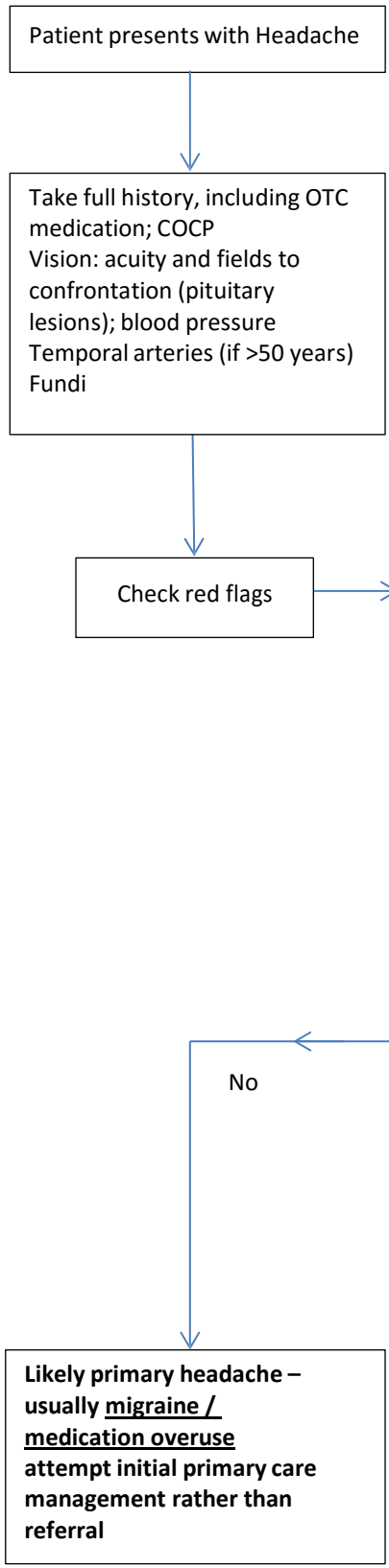
- Most headache is migraine (intermittent or chronic) – probably up to 90%
- Stress, sinuses, eyesight are not usually causes of headaches
- MOH is common – and underdiagnosed; if suspected stop analgesics and caffeine intake
- Review medication (COCP in migraine, medication overuse headache - MOH)
- 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 headache**
- **Trigeminal neuralgia;**
- **SUNCT/SUNA**
- **Cluster headache**
- **HC / CPH**
- **Refractory chronic migraine**
- **Unclassifiable, atypical headache or failure to respond to standard 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 + tears
 SUNA - severe unilateral neuralgiform headache with autonomic features (peri-ocular swelling usually)
 CPH – chronic paroxysmal hemicrania
 HC - hemicrania continua
 SAH – subarachnoid haemorrhage
 ICP – intracranial pressure
 TN – trigeminal neuralgia



Red Flags

- Thunderclap headache (intense headache of “explosive” onset suggest **SAH**)
- Visual loss - ? **pituitary, raised ICP**
- papilloedema
- Age >50 / Scalp tender / Jaw claudication: check urgent ESR /CRP (if suspected **temporal arteritis** - refer & start steroids immediately, prednisolone 40-60mg daily, 60mg if visual symptoms; see BNF)
- Headache with atypical aura (duration >1 hour, or including significant / prolonged motor weakness)
- Headache associated with postural change (bending), straining, exertion or coughing or waking from sleep (possible **raised ICP**)
- Pain worse / occurring upright (postural) – **low CSF pressure headache**
- **New daily persistent headache**
- Unilateral red eye – consider angle closure **glaucoma**
- Remember **carbon monoxide** poisoning (also causes lethargy + nausea)
- Rapid progression of sub-acute focal neurological deficit
- Rapid progression of unexplained personality / cognitive / behavioural change
- New onset headache in a patient with a history of cancer / immunosuppression
- Progressive headache, worsening over weeks or longer
- Refractory headache
- Unclassified headache

Yes

- Walton Centre advice line: Weekdays 11.30-1.30 ([07860481429](tel:07860481429))
- Open access MR scan if available
- Refer
- Admit (As clinically appropriate)

Based on the Pan Mersey Guideline with kind acknowledgement to The Walton Centre NHS Foundation Trust
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