ADULT HEADACHE – GUIDELINE REVIEW

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. (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, dysphasia, 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 **TENSION TYPE HEADACHES:** Episodic or chronic, pressing or tightening and non pulsating, mild to moderate intensity, bilateral, not worse with activities, generally short lasting-no more than several hours **CLUSTER:** intense pain, unilateral, involving eye and frontal region, several times in 24 hours, can last 15-180 minutes. Associated symptoms: lacrimation, nasal congestion, rhinorrhoea, forehead/facial sweating, ptosis/miosis, eyelid oedema. Often occurs in bouts for 6-12 weeks, once a year or 2 years, often at same time of each year **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. 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. The person is usually free of pain at night. **MEDICATION OVERUSE HEADACHES:** Associated with OPIODS, 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of rather than for headache Diagnosis based on symptoms and drug use and confirmed only when symptoms improve after Rx withdrawn
RED FLAG SYMPTOMS Telephone No: Fax No:	Maximum intensity within 5 minutes of onset 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 extensor 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 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/Asprin/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:* Gabapentin (up to 1200 mg per day) or x 10 sessions of acupuncture 3rd line: Riboflavin 400 mg once a day (unlicensed)
	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:** 1ST line: Indomethacin (avoid alcohol/nitrates)Triptans (Sumatriptan 1st choice). 100% Oxygen (Medicine Management to provide guidance on referral Through their bite size newsletter. Consider referral. **Prophylaxis**: *1st line:* Verapamil *2nd line:* Topiramate or valproate (Amitriptyline in pregnant women)
	C.Medication overuse headaches: TREATMENT IS WITHDRAWAL OF ANALGESICS. NSAIDs, Ergots, triptans and non opiods can be stopped abruptly Can lead to withdrawal headache lasting 2-10 days (average 3.5 days) Consider Prophylaxis for the underlying primary headache Opiods/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 *2nd line:* Gabapentin 300mg OD, increasing as BNF up to 1.8gm/day *3rd line:* Phenytoin 100mg OD slowly increasing to 200mg od *4th line:* Sodium valproate: try 200mg BD increasing to 2.4gm
AMITRIPTYLINE is not currently mentioned in the NICE guidelines!! We all like to use this cheap and EFFECTIVE treatment for pain which can be invaluable in the management of headaches and would like Rotherham Gps to continue to use it whenever they feel it is clinically appropriate	
	References: Prodigy - BASH Guidelines 2010 - Sheffield Guidelines NICE Guidelines http://www.guidance.nice.org.uk/cg150
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