ABUHB HEADACHE REFERRAL & TREATMENT GUIDELINES FOR PRIMARY CARE *(v1.1 revised July 2019)*

Please tick at the right column after each step has been completed

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Urgent Assessment	**"RED FLAG" HEADACHE** * Thunderclap headache * Headache associated with possible meningo/encephalitis * Associated with neurological signs (e.g papilloedema) * Associated with new onset seizures * Early morning headache/waking from sleep (not migraine or cluster) * Orthostatic headache (headache that changes on posture) * Headache precipitated by Valsalva manoeuvre/exercise/cough * Headache following major head injury. * New onset headache with primary cancer elsewhere * New onset headache in a patient over fifty years old/suspicion of giant cell arteritis * Headache with cognitive dysfunction. * Symptoms and signs of acute narrow-angle glaucoma * Suspicion of carbon monoxide poisoning.	**A** Arrange brain imaging and consider immediate assessment if required **B** Consider urgent referral to medicine or neurology services. Consider immediate assessment in A&E/MAU if necessary	
Primary Care Management	**MEDICATION OVERUSE HEADACHE (MOH)** * Be alert to the possibility of medication overuse headache in people whose headache developed or worsened while they were taking the following drugs for three months or more: * triptans, opioids, ergots or combination analgesic medications on eight days per month or more **or** * Paracetamol, aspirin or an NSAID, either alone or any combination, on fifteen days per month or more.	**A** Advise people to stop taking all overused acute headache medications for at least one month and to stop abruptly rather than gradually. **B** Advise people that headache symptoms are likely to get worse in the short term before they improve and that there may be associated withdrawal symptoms, and provide them with close follow-up and support according to their needs. **C** Consider prophylactic treatment for the underlying primary headache disorder in addition to withdrawal of overused medication for people with medication overuse headache. **D** Consider specialist referral for people who are using strong opioids, or have relevant comorbidities, or in whom previous repeated attempts at withdrawal of overused medication have been unsuccessful. **E** Review the diagnosis of medication overuse headache and further management four to eight weeks after the start of withdrawal of overused medication. **F** A more detailed information sheet on MOH is available on request from the Neurology department	
	EPISODIC TENSION-TYPE HEADACHE (eTTH) * Headache < fifteen days per month * Pressure/tightness/heaviness/squeezing * Dull, featureless, bilateral or unilateral pain, not aggravated by routine activities * Cause unknown, often associated with anxiety or depression **CHRONIC TENSION-TYPE HEADACHE (cTTH)** – use headache diary (attached) * Same as episodic tension type headache occurring for more than fifteen days per month for more than three months	**A** Lifestyle and trigger modification (stress, caffeine, sleep etc) **B** Non-pharmacology: manage depressive symptoms/stress management/exercise/cognitive behaviour therapy/relaxation therapy **C** Symptomatic treatment: Aspirin 900 mg prn or Paracetamol 1000 mgs prn. Avoid codeine or stronger opiates based due to risk of dependence and medication overuse **D** Preventative treatment: Amitriptyline 10 – 25mg nocte, increasing by 10 - 25 mgs every week until on maximum 150 mgs daily (if no contraindications). **E** Consider other tricyclics or Mirtazapine **F** The NICE guidelines recommend directing cTTH patients to acupuncture, though not available on NHS **G** If symptoms still unresolved/ ineffective treatment/ diagnosis in doubt, refer to neurologist	
	CERVICOGENIC HEADACHE * Patient usually age > fifty or younger with history of neck trauma * Pain due to atlanto-axial joint degeneration * Constant, non-pulsatile, unilateral pain, locked to one side, can radiate to forehead, temple, ear * Tender craniocervical junction	**A** Simple analgesics or NSAIDs on a regular basis (e.g Diclofenac 50 mgs tds for fourteen days) **B** If no response, refer to physiotherapist for assessment **C** If all else fails or concern regarding diagnosis, refer to neurologist	
	CLUSTER HEADACHE (Trigeminal Autonomic Cephalalgias) * Excruciating unilateral periorbital pain lasting up to three hours, usually occurring 1-3 times / 24hrs, typically waking the patient from sleep. * Unilateral autonomic features – (lacrimation, rhinorrhoea, conjunctival injection, ptosis, miosis etc) * Daily attacks during cluster period – classically six to eight weeks in duration	**A** MRI brain and pituitary for new onset cluster headache, to exclude secondary structural cause **B** Refer to neurologist for diagnostic confirmation and a management plan **C** Symptomatic treatment may be initiated by GP whilst awaiting referrals; * Sumatriptan 6 mgs subcutaneously * Nasal triptans e.g. Zolmitriptan 5 – 10mg nasal spray * Home oxygen therapy 100% at 10 – 15 L/min for 15 minutes * Prophylaxis with verapamil 80mg tds after a normal ECG can be commenced in primary care. A more detailed information sheet on verapamil and prednisolone use in cluster headache is available on request from the neurology department	
	MIGRAINE (encourage use of headache diary – available online or on request) * Recurrent severe, uni/bilateral pain with/without aura lasting four to seventy-two hours (or longer) * Pulsating, moderate or severe pain intensity	**A** Acute symptomatic treatment – (***see figure 1***) **B** Preventative treatment – (***see figure 2***) and assess effectiveness Treatment deemed as failed if: *not tolerated, or no response at maximal dose after 3 months for each trial* **C** Consider non-pharmacological management: stress management/exercise/cognitive behavioural	

Primary Care Management	* May be associated with phonophobia, photophobia or movement sensitivity * Two out of three of the following has high sensitivity for migraine: i) Three months of recurrent headache ii) Associated with nausea iii) Light sensitivity more pronounced with headache	therapy/relaxation therapy. This may be considered alongside preventative/symptomatic treatment. Consider triggers, e.g. caffeine, too much/little sleep, menstrual cycle, stress. **D** If symptoms unresolved: reconfirm diagnosis, reassess lifestyle advice, check usage and compliance of treatment, rule out medication overuse headache **E** Consider routine referral to neurology for advice or review if: complication of migraine has developed (chronic); diagnosis uncertain, change in character of migraine, treatment in primary care does not adequately control symptoms/reduce frequency (i.e. failure of adequate trials of 3 preventative drugs) **F** Consider urgent referral or admission if: serious cause of headache suspected; patient in severe, uncontrolled status migrainosus (lasting > seventy-two hours)	

Figure 1 – therapeutic ladder for acute treatment of Migraine (see NICE and BASH guidelines for more info)

Level	Recommended Treatments	Indication
First Line	Simple Analgesia, e.g. 1 Soluble aspirin 900 mgs +/- antiemetic (10mg domperidone) **OR** 2 Triptans (see formulary) +/- antiemetic (domperidone) - if one triptan is not helpful, try another **OR** 3 Ibuprofen 400 – 600 mgs +/- antiemetic (domperidone) **OR** 4 Soluble paracetamol 1000 mgs +/- antiemetic (domperidone)	Any migraine headache of any severity
Second Line	Combination therapies, e.g. Triptan & soluble aspirin +/- antiemetic (domperidone) **OR** Triptan & soluble paracetamol +/- antiemetic (domperidone)	Migraine which failed to respond to First Line or associated with significant nausea or vomiting
AVOID	All opiates should be avoided as they are typically ineffective and lead to dependence and medication overuse headache.	

Figure 2 – Preventative treatment of migraine; should be given for at least three months at its maximum tolerated dose before impact assessed, and if successful continued for approximately six months and then tailed off

Level	Drugs	Suggested Dosing Schedule	Indication/comment
First Line	Beta-blockers, e.g. Propranolol *Or* Topiramate	80mg MR increased to 160mg MR if tolerated 25 mgs once daily, increasing by 25 mgs every two weeks until 50 mgs twice daily	Caution asthma Potentially teratogenic
Second Line	Amitriptyline (unlicensed)	10 – 25mg at night, can be increased by 10 - 25mg mgs every week to 75 – 150mg	First line in child bearing age and Asthma
Others (unlicensed)	Candesartan Riboflavin Acupuncture	Up to 16mg per day (as per BNF titration) 400mg once daily 5-8 week course of up to 10 sessions	Avoid **gabapentin/pregabalin** (ineffective) and **sodium valproate** (MHRA instruction) in all cases of women of child bearing potential
Chronic migraine	Botulinum toxin Or Erenumab (CGRP inhibitor)	Injections as per PREEMPT study – requires referral to neurology Limited availability from drug company (Novartis) – requires referral to Dr K Dawson, Dr J Anderson or Dr F Joseph	Where three prophylactic agents at adequate dose have failed and fifteen headache days per month with at least eight of these due to migraine in absence of medication overuse headache

Dr J G Llewelyn, Dr K Dawson, Neurology Directorate, ABUHB, 2013
Revised: **Dr J Anderson** (July 2019)
Note: some of the medication recommendations are for unlicensed indications

Source:

1 Map of Medicine Pathway for Headache in Adults
2 “Managing Headache in General Practice: a New Approach” by Dr Raeburn Forbes and Dr Orla Gray
3 NICE Guidelines: Headaches, CG150: September 2012 (Updated 2015)
4 NICE TA250: Botulinum toxin type A for chronic migraine: June 2012.
5 British Association for the Study of Headache Management Guidelines 3rd Edition 2010