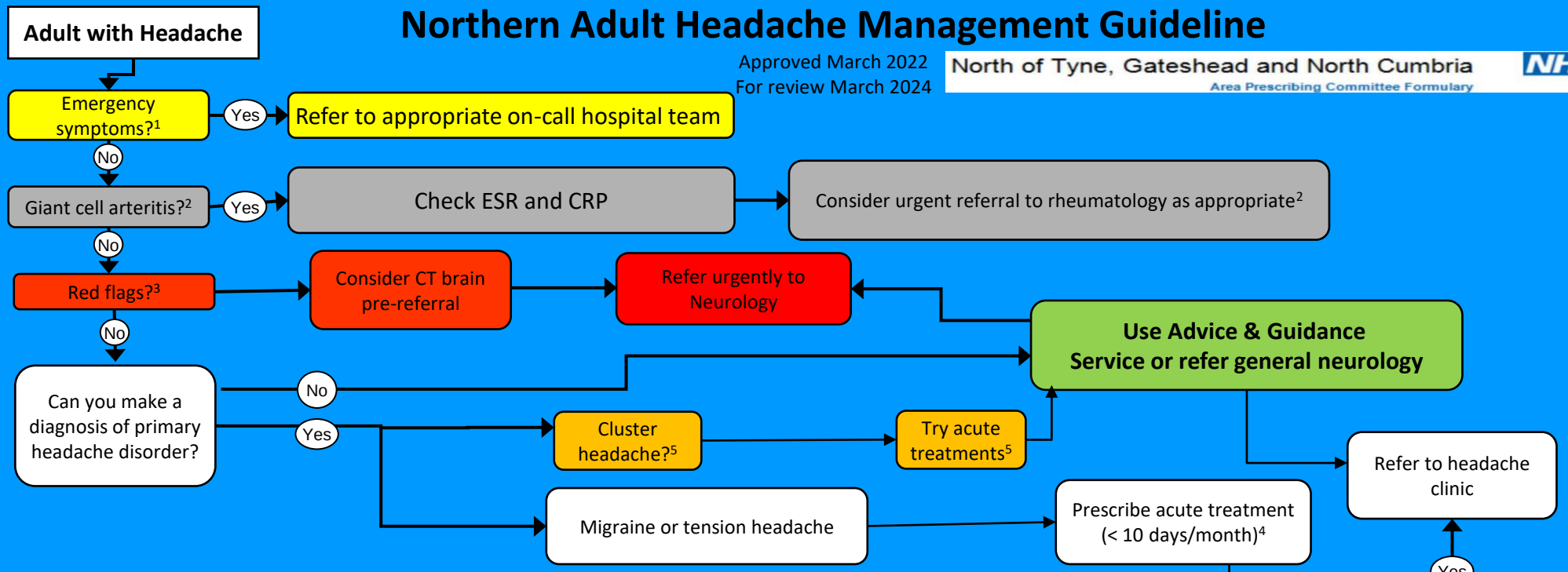
Northern Adult Headache Management Guideline

Approved March 2022
For review March 2024

North of Tyne, Gateshead and North Cumbria NHS
Area Prescribing Committee Formulary



- Direct patient to https://migrainetrust.org ; www.bash.org.uk/guidelines; **Use headache diaries** (see box below)
- Consider stopping combined oral contraceptive. **Note**: combined OCP is contraindicated in migraine with aura
- **Ensure not overusing analgesics or triptans[6]:** Any analgesia or caffeine no more than 2 days per week. Aim for reduced analgesics for at least 1 month. Warn patient headache may get worse before get better.
- **Lifestyle modifiers** for headaches (regular sleep, fixed wake times, hydration, cut out caffeine, trigger avoidance, stress management techniques, normalise BMI, daily aerobic exercise)
- **Migraine prophylaxis**: Try the following for **3 months at the highest tolerated target dose** before judging efficacy:-

a) Propranolol MR 80mg o.d. increasing gradually to a maximum of 240mg a day;

b) Topiramate 25mg o.d. increasing by 25mg every fortnight aiming for a target of 50mg-100mg b.d. **NOTE**: teratogenic and potential interaction with oral contraceptives. Increasing in 15mg increments can enhance tolerability. Often causes paraesthesia, cognitive effects, weight loss, and depression.

c) Amitriptyline or nortriptyline (not approved for all formularies) 10mg nocte, titrated up to 50-70mg; or candesartan up to at least 12-16mg od (max 32mg od) with renal blood monitoring (unlicensed use).

d) If natural products preferred: riboflavin 400mg (not NHS prescribed) or acupuncture.

- www.newcastle-hospitals.nhs.uk/services/neurosciences/neurology/headache-clinic/ (for RVI only)
- Migraine and headache diary - National Migraine Centre

1)

Emergency Symptoms/signs

Thunderclap onset (i.e. max intensity in <5 mins)
Accelerated/Malignant hypertension
Papilloedema
Acute onset with focal neurological signs
Head trauma with raised ICP headache
Photophobia + nuchal rigidity + fever +/-rash
Reduced consciousness
Acute red eye: ?acute angle closure glaucoma
New onset headache in:

- 3rd trimester pregnancy/early postpartum
- Significant head injury
  (esp. elderly/ alcoholics / on anticoagulants)

2)

Giant Cell arteritis (Incidence 2/10,000/ year)

- Think about it: New headache in >50 year old
- Other headaches may briefly respond to high dose steroids, so do not use response as the sole diagnostic factor.
- ESR can be normal in 10% (check CRP as well)
- Symptoms of classical GCA can include: jaw/tongue claudication, visual disturbance, temporal artery: prominent, tender, diminished pulse; other cranial nerve palsies, limb claudication

Urgent referral: rheumatology if GCA diagnosis suspected, ophthalmology or TIA clinic if amaurosis fugax / visual loss / diplopia (not migrainous auras!). Consult local pathway when considering prednisolone treatment.

3)

Red Flags

- New headache rapidly increasing in severity and frequency despite appropriate treatment
- New persistent headache for more than 4 weeks
- Orthostatic headache (changes with posture)
- New onset headache during exertion or Valsalva manoeuvres
- New onset progressive headache in:-
  - >50 years old (consider giant cell arteritis)
  - Patients with focal neurological signs or change in personality
  - Immunosuppressed / HIV

Patient in GP setting: Who to scan ?

Basically, no-one who does not need referring in needs a scan. However, if a scan is being done for reassurance, a CT head scan will suffice.

Overview | Headaches in over 12s: diagnosis and management | Guidance | NICE (www.nice.org.uk/Guidance/CG150) May 2021

4)

Migraine at least 2 of the following features:

- Throbbing pain lasting hours - 3 days
- Unilateral
- Moderate to severe intensity
- Aggravated by physical activity (prefers to lie/sit still)

Plus any one of:

- Sensitivity to light and sound, sometimes smells
- Nausea

Aura (if present):-

- evolves slowly (in contrast to TIA/stroke)
- lasts minutes - 60min

'Chronic Migraine'

≥15 headache days/month of which ≥8 are migraine

Acute treatments:

Aspirin disp. 900mg or NSAID, taken with prochlorperazine
A triptan, no more than 10 days per month (best <6/month)
Don't use opiates as risk of increased nausea and overuse headache
Better efficacy with anti-emetic, or non-oral (e.g. diclofenac supp, s/c or nasal triptan)

Tension Type Headache

Mostly featureless, band-like ache headache
Can have mild photo OR phonophobia but NO nausea
Not functionally limiting

5)

Cluster Headache

Most severe pain ever lasting 30-120 minutes
Unilateral, side-locked
Agitation, pacing (cf migraineurs prefer to keep still)
Unilateral Cranial Autonomic features:-
tearing, red conjunctiva, ptosis, miosis, nasal stuffiness

Acute treatments:

Sumatriptan injection 6mg s.c. or nasal spray (Contraind.: IHD and stroke)
Hi-flow oxygen through a non-rebreathe bag and mask or demand valve (12-15litres/min) via HOOF form on https://sintesi.dolbyvivisol.com/
Prednisolone 60mg o.d. for 1 week, reducing by 10mg every 2 days with PPI can abort a bout of attacks

6)

Analgesic/Triptan Overuse Headache

Often mixture migraine and background headache
Analgesic intake ≥15 days/month (opiates/triptans ≥10 days) for ≥3 consecutive months
Treatment: stop analgesic and triptan for 2 months and follow up
https://migrainetrust.org/understanding-migraine/types-of-migraine/medication-overuse-headache/