Northern England Headache Guidelines

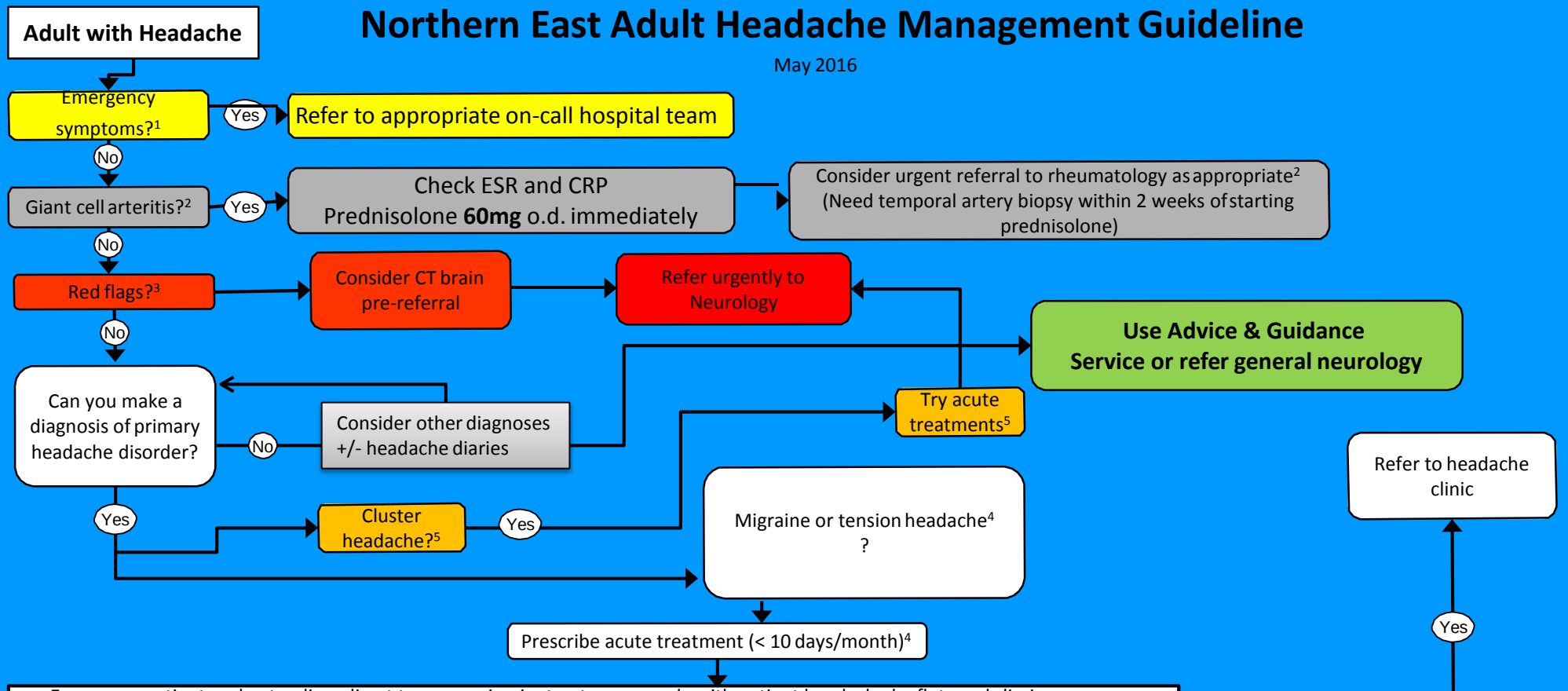
An electronic version of this document can also be viewed / downloaded from the North of Tyne Medicines Optimisation Website at

http://medicines.necsu.nhs.uk/guidelines/north-of-tyne-guidelines/

Endorsed for use within North Tyneside, Northumberland, Newcastle and Gateshead by the North of Tyne APC	
Guideline update	May 2016
Membership of the guideline development	Northern England Strategic Clinical Networks
Consultation Process	This guideline was adapted from a guideline initially developed by a working group convened by the North West Strategic Clinical Network comprising: • Dr Adam Zermansky, Consultant Neurologist, Salford • Dr Raza Ansari - GPwSI, Lancashire • Dr Steven Elliot – GPwSI, Greater Manchester • Dr Hedley Emsley – Consultant Neurologist, Lancashire Teaching Hospitals • Dr Partha Ganguli – GPwSI, Lancashire • Siobhan Jones - Specialist Nurse, SRFT Paul Goldsmith (Consultant Neurologist at NuTH) adapted the North West guideline initially so it was relevant to the North East area (working with Gina Kennedy (chair of the Headache Interest Group) and Paul Dorman. Paul Goldsmith presented this to the medicines optimisation group in Tees and has been in liaison with medicines optimisation in Sunderland. Further adaptations were made to the medication advice following this. Dr Naomi Warren (Consultant Neurologist at NuTH) further adapted the guideline to meet local need. Update has had input from Dr Frances Naylor, GP Northumberland and Sam O'Connell, Pharmacist Sunderland CCG.

Northern East Adult Headache Management Guideline

May 2016



- Encourage patient understanding: direct to www.migrainetrust.org ; supply with patient headache leaflets and diaries
- If relevant, consider stopping combined oral contraceptive. **Note**: combined OCP is contraindicated in migraine with aura
- **Ensure not overusing analgesics or triptans[6]:** Occurs if any of acutes being taken on average >2 days per week. Also similar effect from caffeine. Warn patient may get worse before get better (usually only for days). But may take up to 3 months for full reset.
- Lifestyle modifiers for headaches (regular sleep, fixed wake times, hydration, cut out caffeine, trigger avoidance, stress and anxiety management techniques, normalise BMI, daily aerobic exercise, monitor alcohol use). **Consider IAPT referral for anxiety.**

Consider prevention if >4/7 per month: try the following for **3 months at the highest tolerated target dose** before judging efficacy:-

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

b) If ineffective or contraindicated: Topiramate 25mg o.d. increasing by 25mg every fortnight aiming for a target of 50mg b.d. **NOTE**: teratogenic and potential interaction with oral contraceptives. Increasing in 15mg increments can enhance tolerability. Often causes paraesthesia (warn patients, not usually a reason to cease) and weight loss. Watch out for worsening depression.

c) Other options [*unlicensed, but standard practice*]: Amitriptyline 10mg nocte, titrated up to 50-70mg; if natural products preferred: riboflavin 400mg – do not prescribe, patients to purchase or acupuncture

Tension Type Headaches: Many believe part of migraine spectrum. Treat as such (often no treatment needed), but watch analgesic overuse.

1)

Emergency Symptoms/signs

Thunderclap onset (i.e. max intensity in <5 mins)
Accelerated/Malignant hypertension
Acute onset with 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!).

3)

Red Flags

- Headache rapidly increasing in severity and frequency despite appropriate treatment.
- Undifferentiated headache (not migraine / tension headache) or new persistent daily headache of recent origin and present for >8 weeks with focal neurological signs or high clinical suspicion of underlying structural cause.
- Recurrent headaches triggered by exertion
- New onset 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.

NICE (2013) *Headaches in young people and adults. Quality standard 42.* www.guidance.nice.org.uk/qs42

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, but no more than 9 days per month (best <6/month)
Don't use opiates as they tend to lead to increase nausea and lead to an overuse headache
Poor absorption common in a headache attack – therefore better efficacy with anti-emetic, or non-oral (e.g. diclofenac supp. s/c or nasal triptan)

Tension Type Headache

Band-like ache
Mostly featureless
Can have mild photo OR phonophobia but NO nausea
Many believe this is simply a milder form of migraine (i.e. same biology and thus similar treatments can be effective)

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 (10-12litres/min) via HOOF form on ouchuk.com
Prednisolone 60mg o.d. for 1 week 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