South West London Primary Care Adult Headache Referral and Management Guidance

**Headache**

- **Tension Type Headache**
  - <8 days/month
    - Simple analgesia (warn about medication overuse)
  - 8-15 days/month
    - Consider starting Amitriptyline
  - >15 days/month
    - Start Amitriptyline
    - Reconsider diagnosis
      - (?) chronic migraine or secondary headache
    - Consider electronic advice and guidance or headache clinic referral.

- **Cluster Headache**
  - (new diagnosis or relapse)

- **For all Headache types**
  - History, examination and consider optician review for Fundoscopy
  - After first Primary Care review if diagnosis is not clear give headache diary and review patient at later date.**
  - If still unclear after review consider electronic advice discussion if specific query or referral to Headache Clinic

- **Analgesic Overuse?**
  - > 15 days/m NSAID / paracetamol
  - > 10 days/m opiates / triptans
  - Supported withdrawal of analgesia. Identify and treat underlying syndrome

- **For all patients offer**
  - Lifestyle advice, trigger factors, review if on COC, headache diary, warn about medication overuse

**Migraine**

- < 8 days/month
  - Acute treatment (consider prophylaxis, ? menstrual migraine)
    - **Repeat Attenders**
      - Community Migraine Management Group (MMG)

- > 8 days/month
  - LIMIT analgesia
  - Prophylactic Rx, any of:
    - Propranolol
    - Topiramate
    - Amitriptyline
    - Candesartan
    - Refer to Community Education (MMG)
    - Failure to respond to 2-3 prophylactics at adequate doses (max tolerated) for at least 2/3 months consider referral to headache clinic

- > 15 days/month any headache (migrainous or not)
  - Exclude medication overuse
  - Start Prophylactic Medication
  - Failure to respond after 1 prophylactic at adequate doses after 2 month period →
  - Refer to headache clinic

**“Amber and Red Flags”: see pages 2 and 3 for advice on screening for potential secondary causes of headache**

**Less common benign diagnoses to consider:**
- Cervicogenic headache (overdiagnosed)
- Primary stabbing headache
- Trigeminal neuralgia
- Primary sex headache
- TACs: Hemicrania Continua, Paroxysmal Hemicrania, SUNCT

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HEADACHE AMBER FLAGS – pause and consider secondary causes.
For all amber pathway patients consider discussion with neurologist via Kinesis/advice and guidance/mobile

>50 yr old with genuinely new headache or symptoms suggestive or GCA (e.g. jaw claudication, PMR)

New headache with recent head trauma within the last 3 months

New headache in 3rd Trimester of Pregnancy or early post-partum

New headache in existing cancer or immunocompromised

Postural headaches

Exercise-induced or cough-induced headaches occurring every time with exercise

New daily persistent headache abrupt onset one day without remission since and without antecedent history of headache

Substantial change in headache phenotype

Urgent FBC, ESR, CRP

Normal ESR, CRP

Raised ESR

Re-evaluate history with headache diary (?) common benign syndrome.
If genuinely new headache consider headache clinic referral

Consider Giant Cell Arteritis and refer to acute medicine
Refer urgently before ESR result if visual symptoms

Consider CT head (direct access local pathway)

Consider electronic advice and urgent referral through acute neurology (?) Migraine ? Pre-eclampsia ? Cerebral venous sinus thrombosis

1. If known to Oncology contact patient’s oncology team directly
2. If not known to oncology consider two week rule referral OR if immunocompromised consider acute neurology referral

? Raised ICP (Headache on recumbency, bending forward, Valsalva ± other raised ICP features)

? Low ICP (Headache occurs rapidly on standing, relieved rapidly on lying)

Consider electronic advice or headache clinic referral

Possible secondary headache:
consider direct access imaging or headache clinic referral

Consider carefully if any red flags. If not, review with headache diary.
If no clear diagnosis evident, consider non-urgent Headache Clinic Referral.

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URGENT
HEADACHE RED FLAGS

- Thunderclap Headaches (<5 minutes to maximum severity)
- Acute headache with loss or alteration of consciousness
- Headache with Systemic symptoms, e.g.
  - Malignant hypertension
  - Meningism
  - Fever
- ? Giant Cell Arteritis + visual symptoms (+/- ↑ ESR)
- Red Eye + Headache (especially elderly)
- Emergency referral

Two Week Rule Referral
If high level of concern discuss with acute neurology service

- New Headache plus Subacute Progressive Focal Neurology
- New Headache Plus Seizures
- New Headache with Personality or Cognitive change not suggestive of Dementia, with no Psychiatric history, and confirmed by witness

- Headache with raised ICP features AND severe vomiting, drowsiness ± papilloedema or visual loss
- Emergency referral

Emergency referral

Consider Angle Closure Glaucoma
(ΔΔ Cluster Headache or related disorder)