Headache Management in Primary Care

Dr Niranjanan Nirmalananthan
Consultant Neurologist

Wednesday 10th of April 2019
Summary

- Why does it matter?
- Classification and diagnosis
- Who to refer / scan?
- Serious & Common headaches
Why does it matter?

- Common
  - 3% of GP consultations
  - 2% of A&E attendances
  - 20% of all acute neurology admissions
  - Up to 25% of General Neurology OPD

- Important – Migraine alone
  - WHO Top 10 causes of disability
  - £250 million direct cost to NHS
    - mostly primary care
  - £2.25 billion absenteeism losses
  - Presenteeism
What do GPs See?

- TTH 21%
- Migraine 72%
- Cluster 2%
- Secondary headaches 5%

Kernick, 2008
Headache – making a diagnosis

• History is everything

• Brief focused examination excludes serious pathology

• For *most* patients tests add (very) little.

• Main question is ? Primary or Secondary
Taking a headache history

- **ONSET**
  - How “sudden” is sudden?
  - “How long did it take to get to its worst“

- **Duration**
  - How long?
  - *Truly constant?* or variable / episodic? Frequency?
  - “Crystal Clear” days?

- **Severity**
  - Link it to duration
    - Minimum / Maximum, proportion at maximum

- **Quality**
  - **Throbbing**
  - Aching, stabbing, etc. etc.

- **Antecedent headache history**
  - *Ever* get headaches?
  - Periods, Hangovers, “Hungry headaches”
  - Triggers, caffeine
  - Cyclical vomiting / Benign childhood vertigo / Abdominal migraine / Travel sickness
Headache history – associated features

- **Migrainous features**
  - Photophobia / Phonophobia / Osmophobia / Kinetophobia
  - Nausea / vomiting
  - **Aura** – visual / sensory / motor / aphasia / etc.

- **Pressure features**
  - Effect of posture
  - *Bending forward*
  - Cough / Sneeze / **Strain**
  - Visual obscurations / Pulsatile tinnitus

- **Cervical features**
  - pain / tenderness / reduced range of movement

- **Autonomic features** (? Cluster headache / TAC)
  - *Unilateral* tearing, conjunctival injection, rhinorrhea, flushing etc.

- **Drug History**
  - Analgesic overuse! OTC meds
  - Drug-induced headache (sildenafil, nitrates, clopidogrel etc. etc.)
Focused Examination

- **Systemically unwell**: tachycardic, hypertensive, fever, rashes
- **Obvious** focal neurological signs
  - Standard neurology
    - Pupils
    - Eye movements
    - Facial sensation / movement
  - Cognition
  - Personality
- Nuchal rigidity ≠ Neck tenderness
- Temporal artery pulsation / tenderness
  - Best palpated anterior to tragus
- **Fundoscopy** (Panoptic)
  - Papilloedema

- **? Bloods**
  - ESR in over 50s
• Contextual information
  • Longitudinal knowledge of patient
  • ± patient’s family
• “The test of time”
  • Most primary care headache is benign and self-limiting
  • 70% of primary care headache, no diagnosis made
• Beware of first impressions lasting
  • Review history if phenotype changes
• Beware of therapeutic trials for diagnosis
• Patient’s hypothesis
# Monthly Headache Diary

**Name:**

**Month:**

**DOB:**

**Year:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Day</th>
<th>Time</th>
<th>Severity (1-10)</th>
<th>Duration (min / hrs)</th>
<th>Nausea (N) / Vomiting (V)</th>
<th>Painkillers (Name / Dose)</th>
<th>Notes (e.g. triggers, period, changes in preventatives, side effects etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Who should I be concerned about?
Red Flags

- Epidemiological features
  - New headache and patient > 50 yo (GCA / SOL)
  - Pregnant or recent post-partum
  - Obesity (IIH)

- Co-morbidity
  - Known cancer
  - Active immunodeficiency
  - Recent (<3m) Head Trauma
  - Family or past personal history of aneurysmal SAH
Red Flags

- **Headache features**
  - Thunderclap headache
  - Raised ICP features
  - New daily persistent headache
  - Headache on exertion
  - New headache with vomiting ++
  - Features of GCA / Acute Glaucoma

- **Signs**
  - Fever, confusion, drowsiness, neck stiffness
  - Any neurological signs
Secondary Headache Disorders
Shouldn’t I have a scan doc?

- Why do they want a scan?
- Clear primary headache phenotype?
  - No!
- Features of brain tumour?
  - TWR
- Not sure what it is?
  - Review with diary
  - Refer, don’t scan
- “Just for reassurance” (patient? doctor?)
  - Incidental abnormalities are common
  - Reassurance doesn’t last
  - Reinforces false beliefs
  - Doesn’t manage symptoms
Imaging results in a consecutive series of 530 new patients in the Birmingham Headache Service

C. E. Clarke · J. Edwards · D. J. Nicholl · A. Sivaguru

- 5 year study – 3 neurologists
  - 3655 new patients with headache disorders
  - 530 (14.5%) were scanned
    - 46% had insignificant abnormalities on MRI
    - 28% on CT.
    - 11 (2.1%) had significant abnormalities.
    - When the neurologist suspected an abnormality 5.5% (1 in 20) had one.
Brain tumours

- Rare:
  - 10/100,000/y

- TWR criteria:
  - Subacute progressive neurological signs (including cognition / personality)
  - New seizures
  - Headache with above or raised ICP features
Brain tumours

• < 10% of brain tumours present with isolated headache
  • “featureless”
  • progressive and persistent
  • +/- raised ICP features
    • Early morning
    • Cough, sneeze, strain precipitates

• Isolated headache in primary care?
  • < 0.05% probability of brain tumour

• Chronic headache? even less likely
36 year old male plumber

- Previously well. Presents to A&E.

- Complains of the worst headache of his life. Came on suddenly. Feels sick, but no vomiting. Wants the light off in the cubicle. Complains his neck hurts.

- His examination is normal.
Thunderclap Headache

- Sudden onset severe headache
  ≠ Thunderclap headache ≠SAH

- Maximum severity **within 5 minutes** (and lasts > 1 hour)
  - 10-25% of true thunderclap is SAH
  - <50% of SAH is isolated thunderclap
Thunderclap headache

- Differential is essentially vascular:
  - SAH
  - Cerebral Venous Sinus Thrombosis
  - Carotid dissection
  - Hypertensive encephalopathy
  - Pituitary apoplexy
  - Reversible Cerebral Vasoconstriction Syndrome

- Primary headache disorders
  - Benign sex headache (coital cephalalgia)
  - Primary cough headache
  - Primary exertional headache
  - Primary thunderclap headache
23 year old female student

- Feeling “grotty” for a few days
- 24 hour progressive history of headache, nausea, neck pain.
Acute bacterial meningitis

• Headache, with photophobia, nausea and vomiting occurs in 80-95%

• Apart from headache the key features are:
  • fever
  • neck stiffness
  • confusion

• Only 40% have all 3 but absence of all 3 excludes bacterial meningitis with a 99% sensitivity
23 ♀, rapid onset of headache 2 weeks post-partum

- **Headache history**
  - Bifrontal throbbing headache, built up in 20 minutes out of the blue
  - Worse on coughing, sneezing and straining
  - Headache is 8/10 severity and persistent for last 3 days

- **Associated Symptoms**
  - Nausea, no vomiting
  - Vision sometimes “dims out”
23 ♀, rapid onset of headache 2 weeks post-partum
Papilloedema

- Haemorrhages
- Cotton wool spots
- Loss of venous pulsations
- Blurred optic disc margin
- Small optic cup
Cerebral Venous Sinus Thrombosis

- **Headache**
  - Present in 90% of patients,
  - often the presenting feature
  - the ONLY feature in 30%
  - Typically has raised pressure features
  - Can present as thunderclap
  - Untreated → complications (ICH, SAH, seizures, coning)

- Refer for urgent assessment and CT / MR venography

- In young, obese women with raised ICP headache and papilloedema consider **Idiopathic Intracranial Hypertension** *but* only after excluding CVST
65 ♀ with new onset headache

- **Headache history**
  - Generalised vague dull headaches, not localised
  - Can’t remember exact onset, “weeks”
  - Persistent but seem worse at night
  - No crystal clear days
  - Headache is 5/10 severity

- **Associated Symptoms**
  - Has felt generally under the weather and a bit depressed
  - Noticed a decrease in appetite and some weight loss
  - General weakness in the upper limbs

- **Antecedent headache history**
  - Mild tension-type headaches in 20s.
Giant Cell Arteritis

- **Headache features**
  - New onset headache in middle age / elderly - **can be any location**
  - Typically continuous and interferes with sleep
  - *Scalp tenderness is NOT specific or particularly sensitive*

- **Other features**
  - Systemically unwell
  - **Jaw claudication (~50%)**
    - occasionally intermittent claudication in the limbs or tongue
  - **visual loss in ~20% (often early) if untreated**
    - sudden, bilateral visual loss can occur, esp. in elderly
  - PMR in 50%, but muscle aches often not prominent

- **Tests**
  - ESR, CRP and FBC
    - ESR typically ≥ 50mm/h, CRP usually high, 50% anaemic

- **Treat if temporal tenderness, ESR > 50, CRP > 5**
  - Start steroids first (60mg od) and refer
Cervicogenic headache

- Headache with neck or scalp tenderness ≠ cervicogenic headache
- Overdiagnosed
  - Inappropriate referral to MSK
  - Undertreatment
- Key features
  - Restricted range of movement
  - Provocative manoeuvres reproduce
Primary Headache Disorders
Primary Headache disorders

- Tension-type headache
- Migraine
- Trigeminal autonomic cephalalgias
  - e.g. cluster headache
- Other primary headaches are rare

- Make a positive diagnosis
Migraine – Management

- Clear, positive diagnosis and a clear plan

- Lifestyle / Triggers
  - Sleep
  - Caffeine
  - COC advice

- Abortive treatments

- Prophylactic therapy

- Education & Self-management
  - Give written information (Migraine Trust / Migraine Action)
  - Explore triggers / lifestyle issues
  - Headache Diary
  - Psychological Co-morbidity
Improving Migraine Management

• **Underdiagnosis**
  • Lack classic migrainous symptoms (especially in chronic migraine)
  • Absence of aura
  • Analgesia overuse
  • Episodic disabling headache is migraine
    • TTH / sinus headache very overdiagnosed

• **Undermanaged**
  • Propagation of analgesia overuse
  • Lack of patient education re: abortives
  • Prophylactic use – dose / duration of Rx
Migraine - Abortive

• Analgesics: **maximum 2 -3 days a week**

• **Treat hard, treat early**
  • NSAIDs
    • High dose, e.g.
      • 600-800 mg Ibuprofen
      • 900mg Aspirin
      • 500mg Naproxen
  • Triptans (not if CV disease)
    • Consider wafers, nasal, subcut in refractory patients
    • At least 3 attacks
    • Try all 7 if necessary
    • Don’t use Triptan response for diagnosis
  • NSAID + Triptan is more effective
  • **DON’T GIVE OPIATES** (or recommend OTC containing opiates, e.g. Migraleve)

• Antiemetics
  • For **gastroparesis ± nausea**
  • domperidone or metoclopramide

• **Severe acute migraine with:**
  • sc sumatriptan / im diclofenac / im metoclopramide
Migraine - Prophylaxis

• If > 8 days a month
  • discuss if 4-8 days a month and major QoL impact
• Good RCT evidence for:
  • Propranolol (target 160mg total, up to 240mg)
  • Topiramate (target 100mg total, up to 200mg)
  • Amitryptiline (target 50mg total, up to 100mg)
  • Candesartan (target 16mg total, up to 32mg)
  • Pizotifen (1.5-3mg total)
  • Valproate (up to 2000mg total)

• High dose for minimum 2-3 months
• Analgesic overuse impacts prophylactic efficacy
• Target 50% reduction in headache severity or frequency
• Wean after ≥ 6 months of stability
• Failed 3 prophylactics? → Botox
Pure Menstrual Migraine

- Frovatriptan 2.5 mg bd or
- Naproxen 500mg bd
- From 3 days before for total 6 days
Migraine in Pregnancy

- Really bad morning sickness
- Worse in 1\textsuperscript{st} TM, much better in TM2/3
- Worse after deliver / stopping breastfeeding

- Paracetamol
- NSAIDs 2\textsuperscript{nd} TM only
- Triptans with caution
Cautions

• Very first episode of severe migrainous headache
  • Image it in the over 50s.
• Very rapid onset of Aura (<5 mins) and prolonged aura (>60 mins) are concerning
• Major change of phenotype can be a sign of additional pathology
35 year old male Accountant

- 5 months of bad bilateral headache, constant for 4 months - there all the time. Varies from 6-9/10 in severity. Feels sick with it, but otherwise featureless.
- Had migraines in his 20s, but very rarely since. When headache started 5 months ago it was a bit like his old migraine, but current headache is completely different.
- When these headaches started, they were not getting better with paracetamol or ibuprofen and now taking daily co-codamol from GP for the last 3 months with some acute relief.
- Examination is normal
AN OVERUSE OF PAINKILLERS CAN CAUSE YOUR BANGING HEADACHES

Taking medicines such as painkillers over a prolonged period of time to relieve headaches can actually make symptoms worse. For more information visit; http://www.nice.org.uk
Medication-Overuse Headache

- **HUGE PROBLEM (1-2% of population)**

- *Any* patient, with *any* episodic primary headache disorder may develop chronic daily headache if given frequent analgesics
  - 10 - 15 /m paracetamol / NSAIDs
  - 8 -10 /m for triptans
  - 6 – 8 /m for opiates
Medication-Overuse Headache

- Increased severity and frequency
- Background headache
- Becomes featureless
- Prophylactics won’t work!

If you see patients with persistent headache on analgesics
  - Try “detox” –
    - “short sharp shock”
    - Wean opiates slowly
  - Limit 2 days per week
  - BAN opiates
  - Start prophylaxis for underlying primary HA
Chronic Daily Headache / Chronic Migraine

• >15 days a month of headache of any kind
  • “8 days migrainous”
• Overwhelmingly, most chronic headache is chronic migraine ± medication overuse headache

• Tips:
  • Always push about analgesic frequency
  • “Crystal clear days”
  • Severity at worst and best?
  • Number of days per week it is at its worst?
  • **Focus on the bad days** to identify migrainous features
  • Identify what the headache phenotype was like before “chronification”
Advanced Therapies

• Nerve blocks
  • > 60% response in chronic headache
• Botulinum toxin therapy
  • NICE approved for Chronic Migraine
  • Failed 3 prophylactics
• Transcranial Magnetic Stimulation
  • NICE IPG
• Implanted occipital nerve stimulation for intractable migraine
• CGRP Monoclonal Antibodies
  • NICE TA pending
Tension-type Headache

- Defined by what it isn’t
- Mild, featureless, bilateral
- Rx
  - Paracetamol or NSAIDs ≤ 2 days pw
  - Explore Triggers / Psychological / Environmental
- Consider prophylaxis if frequent 8-15 days a month (risk of medication overuse headache)
  - Amitryptiline, Venlafaxine, Mirtazepine
- >15 days a month – think again
  - Migraine? Secondary disorder?
Cluster Headache
Cluster headache

- **History:**
  - Occurs in **clusters**
    - several attacks a day for weeks / months,
    - then remission
  - **Strictly unilateral**
  - Excruciatingly severe, frontal / retro-orbital
  - Attacks shorter than migraine
    - 30 min – 4 hours
    - Up to 8 times a day
  - Ultradian rhythms (more often at night)
  - Patients are **restless** (cf migraine)

- **Trigeminal autonomic features**
  - Ptosis, tearing, conjunctival injection, flushing, rhinorrhea
Cluster headache

• **Acute treatment:**
  • High flow O2 – aborts most attacks
    • *100% via non-rebreathe mask*
  • Sc sumatriptan 6mg
  • Nasal triptans may work (less effective)
  • Oral triptans do *not* work

• **Prevention:**
  • High dose prednisolone at cluster onset, tapering
  • Greater Occipital Nerve Block at start of a cluster
  • Start Verapamil (or Lithium / Topiramate)
Other primary headaches

• Occasional severe brief stabs?
  • Primary stabbing headache

• Waking up head feels like it exploded?
  Exploding head syndrome

• Short lasting, unilateral neuralgic headaches, with conjunctival injection and tearing?
  • SUNCT
Who to refer with primary headaches?

- Everyone with cluster headache and related disorders
- Refractory high frequency episodic migraine
  - Failed on 2-3 prophylactics
- Difficult chronic migraine ($\geq 15$ per month)
- Botox candidates (Chronic Migraine failed on 3 prophylactics)
- Not sure of diagnosis?
- Other comorbid headache disorder?
- Difficult to address analgesic overuse
Finally, a few headache myths

- Tension-type headache is not “caused by stress”

- Refractive error does not cause headache – it causes eyestrain

- Nearly 90% of patients with self or physician-diagnosed “sinus headache” have migraine.
Headache Service, SGH

- **Team**
  - Dr Niran Nirmalananthan
  - Dr Usman Khan
  - Dr Bhavini Patel
  - Dr Katharine Pink
  - Dr Arani Nitkunan (IIH / GCA)
  - Ms Anne-Marie Logan

- **Contact for advice:**
  - Niran Nirmalananthan or Anne-Marie Logan
    - *via Kinesis*

- **Urgent advice:**
  - Neurology Registrar / Acute Neurology Team bleep 7277
Summary

- Headache in primary care is overwhelmingly benign and a positive diagnosis can be made
- Can usually be effectively managed in primary care
- Imaging needed in very few cases
- Refer, rather than scan, if uncertain
DRAFT: Wandsworth and Merton Primary Care Adult Headache Pathway

Headache
- Exclude Red Flags – See Overleaf

Tension Type Headache
- <8 days/month
  - Simple analgesia (warn about medication overuse)
- 8-15 days/month
  - Consider starting Amitriptyline
- >15 days/month
  - Start Amitriptyline
  - Consider angle-closure glaucoma as differential in elderly

Cluster Headache (new diagnosis or relapse)
- Acute Neurology Clinic / Headache Clinic for urgent review
- Consider kinesis query or headache clinic referral.

History, examination and Fundoscopy. This to be for all Headache types.
- After first Primary Care review if diagnosis is not clear give headache diary and review patient at later date.

Migraine
- Low Freq
- High Freq
- Chronic

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

<8 days/month
- Acute treatment, (consider prophylaxis)
- Repeat Attenders
  - Community Education (Community Migraine Advice Clinic, CMAC)

>8 days/month
- Prophylactic Rx, any of:
  - Propranolol
  - Amitriptyline
  - Topiramate
  - Refer to Community Education (CMAC)

>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.

V2.1 May 2017 Niranjan Nirmalanathan / Aditi Shah
For all patients offer Lifestyle advice, trigger factors, review if on COC, headache diary, warn about medication overuse

Migraine

Low Freq

<8 days/month
Acute treatment, (consider prophylaxis)
Repeat Attendees
Community Education (Community Migraine Advice Clinic, CMAC)

High Freq

>8 days/month
Prophylactic Rx, any of:
- Propranolol
- Amitriptyline
- Topiramate
Refer to Community Education (CMAC)

Chronic

>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.
DRAFT: Wandsworth and Merton Primary Care Adult Headache Pathway

- **Headache Amber Flags** (Moderately Urgent)
  - Normal ESR
  - Reevaluate history with headache diary (? common benign syndrome). If genuinely new headache consider imaging.
  - Raised ESR
  - Consider GCA and manage as appropriate

- **>50yr old with genuinely new headache or symptoms suggestive or GCA (e.g. jaw claudication)**
  - FBC, ESR, CRP,
  - Consider CT

- **New headache with recent head trauma within the last 3 months**
  - Consider carefully if any red flags. If not, review with headache diary. If no clear diagnosis evident, non-urgent Headache Clinic Referral.

- **Substantial change in headache phenotype**
  - MRI and share pictures via PACS (in-health or AQP must share images) **OR** Direct two week rule referral.

- **New headache in existing cancer or immunocompromised**
  - Consider secondary cause.
  - Low CSF pressure: headache only on standing(? Spontaneous CSF leak)
  - Raised ICP: headache on recumbency, Valsalva, bending forward ± other raised ICP features? SOL / IIH / CVST?
  - Consider MRI, discussion via Kinesis or Headache Clinic Referral

- **Postural headaches**
  - Consider MRI (? Posterior fossa lesions)

- **Exercise induced headaches** (occurring every time with exercise)
URGENT
HEADACHE RED FLAGS

Thunderclap Headaches (<5 minutes to maximum severity)

Acute headache with loss or alteration of consciousness

Headache with Systemic symptoms
- Malignant hypertension
- Meningism
- Fever

GCA + ESR

Visual Symptoms

Red Eye + Headache (esp elderly)

Consider Angle Closure Glaucoma
(Δ△ Cluster Headache or related disorder)

- Headache plus Progressive Focal Neurology
- Headache Plus Seizures
- Headache with Personality or Cognitive change not suggestive of Dementia, with no Psychiatric history, and confirmed by witness
- Non-migrainous Headache with raised ICP features (marked postural variation, vomiting, drowsiness, papilloedema)

A & E

Two Week Referral