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

Headache

Tension Type Headache

**Migraine**

**Analgesic Overuse?**

> 15 days/m NSAID / paracetamol

 > 10 days/m opiates / triptans

 Supported withdrawal of analgesia.

Identify and treat underlying syndrome

8-15 days

/month

****

Consider starting Amitryptiline

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

Cluster Headache

(new diagnosis or relapse)

For all Headache types

**History, examination and consider optician review for Fundoscopy**

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

>15 days

/month

Start Amitryptiline

**Reconsider diagnosis**

(? chronic migraine or secondary headache)

Consider electronic advice and guidance or headache clinic referral.

1. Reconsider Diagnosis

<8 days

/month

****

Simple analgesia (warn about medication overuse)

M

Acute Neurology Clinic / Headache Clinic for urgent review

Consider angle-closure glaucoma as differential in elderly

High Frequency

Low Frequency

**Chronic Migraine** sssdfMmmMMMMMmMigraine

> 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

> 8 days/month

LIMIT analgesia

Prophylactic Rx, any of:

* Propranolol
* Topiramate
* Amitriptyline

****

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

< 8 days/month

Acute treatment (consider prophylaxis, ? menstrual migraine)

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**Repeat Attenders**

Community Migraine Management Group (MMG)

\*\*Less common benign diagnoses to consider:

* Cervicogenic headache (overdiagnosed)
* Primary stabbing headache
* Trigeminal neuralgia
* Primary sex headache
* TACs: Hemicrania Continua, Paroxysmal Hemicrania, SUNCT

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

Re-evaluate history with headache diary

(? common benign syndrome).

If genuinely new headache consider direct access MRI or referral

Normal ESR, CRP

**Urgent** FBC, ESR, CRP

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

Raised ESR

Consider Giant Cell Arteritis and refer to acute medicine

Refer urgently before ESR result if visual symptoms

Consider CT head

(direct access local pathway)

New headache with recent head trauma within the last 3 months

Substantial change in headache phenotype

Consider carefully if any red flags. If not, review with headache diary.

If no clear diagnosis evident, consider non-urgent Headache Clinic Referral.

New daily persistent headache

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

Possible secondary headache:

consider direct access MRI scan **or** headache clinic referral

Exercise-induced or cough-induced headaches

occurring every time with exercise

Consider direct access MRI (? posterior fossa lesions) **or** electronic advice **or** headache referral

? SOL ? IIH - if typical raised ICP headache refer TWR

If unclear consider headache clinic referral

If no recent LP or other spinal procedure, consider direct access MRI *with contrast*  **OR** electronicadvice / headache clinic referral

Or

Postural headaches

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

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

New headache in existing cancer or immunocompromised

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

Consider electronic advice and urgent referral through acute neurology

(? Migraine ? Pre-eclampsia ? Cerebral venous sinus thrombosis)

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

* **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**
* ****

**URGENT**

**HEADACHE RED FLAGS**

**Thunderclap Headaches (<5 minutes to maximum severity)**

**Two Week Rule Referral**

If high level of concern discuss with acute neurology service

**Acute headache with loss or alteration of consciousness alteration of consciousness**

* **Headache with raised ICP features AND severe vomiting, drowsiness ± papilloedema or visual loss**

**Headache with Systemic symptoms, e.g.**

* Malignant hypertension
* Meningism
* Fever

**? Giant Cell Arteritis + visual symptoms (+/- ↑ ESR)**

**Red Eye + Headache (especially elderly)**

**Emergency referral**

Consider **Angle Closure Glaucoma**

(ΔΔ Cluster Headache or related disorder)

**Emergency referral**

**(Eye clinic)**

**Emergency referral**