Lancashire & South Cumbria Medicines Management Group

Primary Care Adult Headache Management Pathway

Version 1.1 – April 2024

VERSION CONTROL		
Version	**Date**	**Amendments made**
Version 1.0	October 2018	Reformatted version 8 of the North West Headache Management Guideline for Adults to match other LMMG guidelines. Amended clinical content in line with NHSE OTC guidance.
Version 1.1	April 2024	Updated in conjunction with LTH neurology. MHRA alert for topiramate added. Valproate/valproic acid is not to be prescribed for migraine prophylaxis added at the request of LSCMMG. Reference to oxygen for cluster headache removed at the request of LSCMMG.

Page

Adult Headache Management Pathway

Adult with a headache

Additional information on headache types – page 2 and 3

Emergency symptoms? See page 4
- Yes → **Refer to appropriate on-call hospital team**
- No ↓

Giant cell arteritis? See page 4
- Yes → Check ESR and CRP; Give stat dose prednisolone 60mg and continue o.d. → **Consider urgent referral to rheumatology, ophthalmology or neurology as appropriate (need temporal artery biopsy within TWO weeks of starting prednisolone)**
- No ↓

2 week wait? See page 4
- Yes → 2WW referral (use neurology 2WW form)
- No ↓

Red flags? See page 4
- Yes → **Refer to headache service OR secondary care**
- No ↓

Consider using a headache diary: is it a migraine or tension headache? See box 1 and page 5
- Yes → **First or infrequent migraines**
  Step 1: simple analgesic +/- anti emetic – **avoid opioid analgesics**
  Step 2: oral triptan +/- simple analgesic. An alternative triptan should be used if unsuccessful.
  See page 5 for details on prophylaxis
- No ↓

Is it 'cluster headache'? See page 5
- Yes → **First or infrequent migraines** (as above)
- No ↓

Other secondary causes?
e.g. sinusitis, TMJ pain
Check: Hb, Calcium, TFT, ESR, CRP
Review lifestyle and medication

↓ No

Suspect:
Medication overuse?
Drug induced? **See box 1 and page 5**
- No → **Refer to headache service (where commissioned) OR secondary care to undertake clinical triage**

  Rimegepant can be considered as per NICE TA 919 and 906 – see page 5
- Yes ↓

Stop suspected medication for 1 month – see page 5
- If unsuccessful → **Is it a migraine or tension headache? See box 1 and page 5**
  - No → **Refer to headache service (where commissioned) OR secondary care to undertake clinical triage** … **Rimegepant can be considered as per NICE TA 919 and 906 – see page 5**
  - Yes → **First or infrequent migraines** (as above)

First or infrequent migraines → If unsuccessful → **Refer to headache service (where commissioned) OR secondary care to undertake clinical triage** … **Rimegepant can be considered as per NICE TA 919 and 906 – see page 5**

Box 1 – Migraine – see page 5 for prophylaxis

- Throbbing pain lasting hours to 3 days
- Sensitivity to stimuli: light and sound, sometimes smells
- Nausea
- Aggravated by physical activity (prefers to lie or sit still)
- Aura, if present, evolves slowly (in contrast to TIA or stroke) and lasts minutes to hours.

Chronic migraine (15 or more headache days per month, of which 8 or more are migraine)

Education and a better understanding of the condition can be facilitated by directing patients to:

- www.nhs.uk/conditions/headaches/ OR
- www.migrainetrust.org

Explain the risk of medication overuse headaches to people using acute treatments (particularly any use of opiates and triptans >10 days a month)

If relevant, consider stopping combined oral contraceptives (note: combined oral contraceptives are contraindicated in migraine with aura)

Lifestyle modification e.g. adequate hydration, sleep, exercise, STOP caffeine, avoid triggers and address psychosocial factors if necessary.

Consider using a headache diary to record the frequency, duration and severity of headaches and to monitor the effectiveness of headache interventions. Can be used as a basis for discussion about headache disorder and impact: https://migrainetrust.org/wp-content/uploads/2021/06/The-Migraine-Trust-headache-diary-Word.docx

Adult Headache Management Pathway – additional information

Giant Cell Arteritis

- Incidence 2/10,000 per year
- Consider with presentations of new headache in people > 50 years old
- ESR can be normal in 10% - check CRP as well

Symptoms may include: jaw or tongue claudication, scalp tenderness, visual disturbance, temporal artery: prominent, tender, diminished pulse; other cranial nerve palsies, limb claudication

Many headaches respond to high-dose steroids. **However,** do not use the response as the sole diagnostic factor.

Tocilizumab for treating giant cell arteritis NICE TA 518: recommended as an option when used with a tapering course of glucocorticoids (and when used alone after glucocorticoids) in adults, only if:

1. they have relapsing or refractory disease
2. they have not already had tocilizumab
3. tocilizumab is stopped after 1 year of uninterrupted treatment at most and
4. the company provides it with the discount agreed in the patient access scheme

Urgent Referral to:
Rheumatology if diagnosis clear Neurology if headache or possibly GCA
Ophthalmology if amaurosis fugax / visual loss / diplopia **NOT** migrainous auras

2 Week Wait – suspected cancer referral

Headache with features of raised intracranial pressure:

- Actively wakes a patient from sleep, but not migraine or cluster
- Precipitated by Valsalva manoeuvres e.g. cough, straining at stool
- Papilloedema

Other symptoms of raised ICP headache include:

- Headache is present upon waking and easing once up (analgesic overuse can cause this pattern) and worse when recumbent.
- Pulse synchronous tinnitus
- Episodes of transient visual loss when changing posture e.g. on standing
- Vomiting – significance should be judged in context as nausea and vomiting are features of migraine Headache with new-onset seizures
- Headache with persistent new or progressive neurological deficit

Emergency symptoms or signs

Thunderclap onset
Accelerated or 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 or early postpartum
Significant head injury – especially elderly patients with alcohol dependency or patients on anticoagulants

Red flags

- Headache rapidly increasing in severity and frequency despite appropriate treatment
- Undifferentiated headache (not migraine or tension headache) of recent origin and present for > 8 weeks
- Recurrent headaches triggered by exertion
- New onset headache in : > 50 years old (consider giant cell arteritis; CNS malignancy); immunosuppressed or HIV or known malignancy

Migraine prophylaxis

Please note: Sodium valproate and valproic acid should **NOT** be used for migraine prophylaxis

The decision to start prophylaxis should be based on the impact of the migraine on the patient's quality of life (e.g. >4 /month). The choice of treatment depends on patient preference, drug interactions and other co-morbidities. Treatment should be started at a low dose and gradually increased to the maximum effective and tolerated dose.

Trial for 3 months titrating dose according to response before judging efficacy

First-line options – to be considered in primary care:

Propranolol MR 80mg once daily, increased gradually to a maximum of 240mg once daily.

Amitriptyline 10mg at night, increased in 10mg every fortnight as necessary to 100mg at night [unlicensed, but standard practice – see NICE CKS: Migraine]

Topiramate 25mg once daily, increased by 25mg every fortnight as necessary to 50mg twice daily.

MHRA/CHM advice: Topiramate

females of childbearing potential or their carers should be counselled on the importance of avoiding pregnancy due to these emerging risks, as well as the established risks associated with topiramate use in pregnancy.

Candesartan 2mg once daily, increased gradually to a **maximum** of 16mg daily.

Advise patients that riboflavin 400mg once daily may be effective in reducing migraine frequency and intensity for some people – purchase OTC (avoid if planning a pregnancy or pregnant).

Second line option – on the recommendation of secondary care:

Rimegepant 75mg **on alternate days**

Eligible for episodic migraine (**as per NICE TA 906**):
Between 4 and 15 migraine attacks per month, *and*
At least 3 preventative medications, at suitable dose/duration, have not worked, *and*
Recommended by a specialist – LSCMMG RAG rating Amber 0

Cluster Headache

More common in men
Severe pain lasting 30-120 minutes Unilateral, side locked
Agitation, pacing (note: migraine patients prefer to keep still)
Unilateral cranial autonomic features: tearing, red conjunctive, ptosis, miosis nasal stuffiness

Acute treatments:
Offer a subcutaneous triptan (nasal triptan can be considered [unlicensed indication]).

Do not offer paracetamol, NSAIDS, opioids, ergots or oral triptans

Tension-Type Headache

Band like ache
Mostly featureless
Can have mild photo OR phonophobia but NO nausea

Treatment:
Aspirin, paracetamol or an NSAID. Do **not** offer opioids

Tension-type headache prophylaxis

Amitriptyline, following the same dose schedule as for migraine above.

Consider acupuncture, if available.

Analgesic Overuse Headache

Can be migrainous and/or tension-type

At risk if analgesic intake ≥15 days per month (opiates ≥ 10 days) for ≥ 3 months OR triptan intake ≥ 10days per month for ≥ 3 months

Treatment: Stop analgesic or triptan for 3 months

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