Quick reference guide for headache management Coventry and Warwickshire

Headache tool

click to open website

General queries about medication ?
General queries about headache specific treatments?
General weblinks for clinicians or patients needed?

Diagnostic features of most common primary headaches

Feature	Migraine (episodic <15 days/month, chronic <15)	Tension headache	Cluster	Hemicrania (H. continua, paroxysmal H.)
Pain	**mild-severe**	**mild-moderate**	**excruciating**	excruciating
Location	in 60% unilateral, usually building up, may spread	Usually frontal or occipital bilateral	**orbito-temporal unilateral**	**orbito-temporal** unilateral
Pain characteristic	Pulsatile, throbbing	**Pressure, band-like**	Stabbing, drilling,	Stabbing, throbbing
Attack duration	4-72h	30 min - days	Attack 30-180 min,	**paroxysmal 2-30 min continua: continuous**
Diurnal variation	Any time	day	**night/early morning**	Any time
Attack frequency	1/d	1/d	0.5-8/d	Paroxysmal 1-14/day
Cluster duration	Rarely several days		1-3 months	
Hypersensitivity	+++	(+)	-/(+)	(+)
Nausea	+++	(+)	(+)	(+)
Vegetative Symptoms	**Needs sleep**/better after sleep		**restless/agitated/self harm**	Often restless
Autonomic features	+	-	+++	+
Specific features	**Motion-sensitive. Polyphasic:** prodromi-**aura**-migraine-hangover, classic triggers, **3rd leading cause of ill health in the UK**	**Can continue to work**	**Men** age 20-50, **smoker**	**Parox H Similar to cluster** but shorter attacks more middle age women, **more migraineous features**

More diagnostic critera needed?
Red flags (what are those?)?
Investigations?
Look up "diagnosis" "red flags"

Attack treatment
hit fast, hard, short, adjust avoid overuse

Start attack treatment AND...

Attack treatment	Migraine	Tension headache	Cluster	Hemicrania
1st step	**Preferably soluble NSAIDs**, Paracetamol, Aspirin 900 mg **antiemetics e.g. metoclopramide**	NSAID Paracetamol	**Non oral triptans** Sumatriptan ns/sc Zolmitriptan ns	NSAID trial triptan trial
2nd step	Triptans. 1st line **Sumatriptan** 50 mg (max300mg/d depending on response **consider alternative triptans or + NSAID**	-	Consider High flow oxygen e.g. via A&E for 20 min	**Triptan trial often not effective. Start indometacin see below**

Initial Attack treatment not effective?
Side effects?
Medication overuse?
Look up Treatment

...inform patients about risks and non pharmacological approaches to avoid deterioration ...

Patient management
To avoid deterioration

Improve Lifestyle	Stop alcohol, caffeine containing drinks, stop smoking, reduce weight if obese, regular exercise, regular food intake, fluid intake 2 l, regular sleep.
Prevent medication overuse	By informing patient about this risk, reviewing ca 8 weeks to adjust attack and prevention treatment
Headache diary (pain causes memory impairment!)	Patient should document: headache days, attack treatment, when prevention was started/increased and if side effects have occurred and lasting >1 week. This helps also to identify triggers and adjust lifestyle\
Patient empowerment	Doing a good headache diary gives patient control over condition and treatment, patient has to initiate reviews.

Patient info leaflets
Tips to speed up Consultation
Look up patient managemenet

In migraine and tension headache consider start of prophylaxis if >4 days of headache/month consistently

In Cluster/Hemicrania consider start of prophylaxis straight way

Prophylaxis
Start low, go slow to target dose, stay for 8 weeks if tolerable side effects, persist for 2 weeks, if no improvement stop Adjust to Comorbidity

Prophylaxis	Migraine	Tension headache	Cluster	Hemicrania
1st step (target dose/d)	Propranolol (80 mg MR OD) Metoprolol cardioselective (100 mg/d) Amitriptyline (50 mg ON) Nortriptyline (50 mg ON)	**NO drugs, avoidance of triggers,** improvement of lifestyle, posture, relaxation, reduce stress	**Do ECG** if no block / bradycardia or other CI consider start **Verapamil IR** (120 mg TDS)	**Indomethacin (75 mg TDS) with PPI.** If effective hemicrania confirmed
2nd step (target dose/d)	Topiramate (75 mg ON , SA drug) Candesartan (16 mg/d) Venlaflaxin (75 mg/d)	Amitriptyline (50 mg ON) Venlaflaxine (75 mg/d) Mirtazapine (15 mg ON)	Topiramate (50 mg ON) Gabapentin (900 mg TDS) Melatonin (10 mg ON)	Topiramate (50 mg BD) Amitriptyline (50 ON) Gabapentin (900 mg TDS)
Alternatives	SA drugs: Gepants, other antiepileptics if **pure menstrual migraine** and predictive cycle: 5 days NSAIDS or Frovatriptan 2.5 mg BD, started 1-2 day before expected migraine	Nortriptyline (50 mg ON)	Prednisolone 60 mg/d for 5 days, step down 10 mg every 5 days until stop	Verapamil (160 mg TDS)

Prophylaxis not working?
Difficult comorbidities?
Questions about pregnancy, menopause, contraception?
Look up treatment

...review every 4-8 weeks prophylaxis AND attack treatment including over the counter painkiller use.
If attack treatment use >15 days/month for >3 months high risk of developing medication overuse headache!

Considering referral?

Referrals	Migraine	Tension headache	Cluster	Hemicrania
to headache clinic	If 3 prophylaxis treatments failed, if management very difficult in primary care if several attempts of reducing medication overuse failed and headaches are getting worse		**Refer URGENTLY on first presentation** Consider CT/MRI	**Referral possible on first presentation.** Consider CT/MRI
A&G Referral	If SA medications to be considered in primary care if particular questions in patients who are still manageable in primary care e.g. comorbidities,			
Further general referral indications: Diagnostic uncertainty, atypical headaches/facial pains				