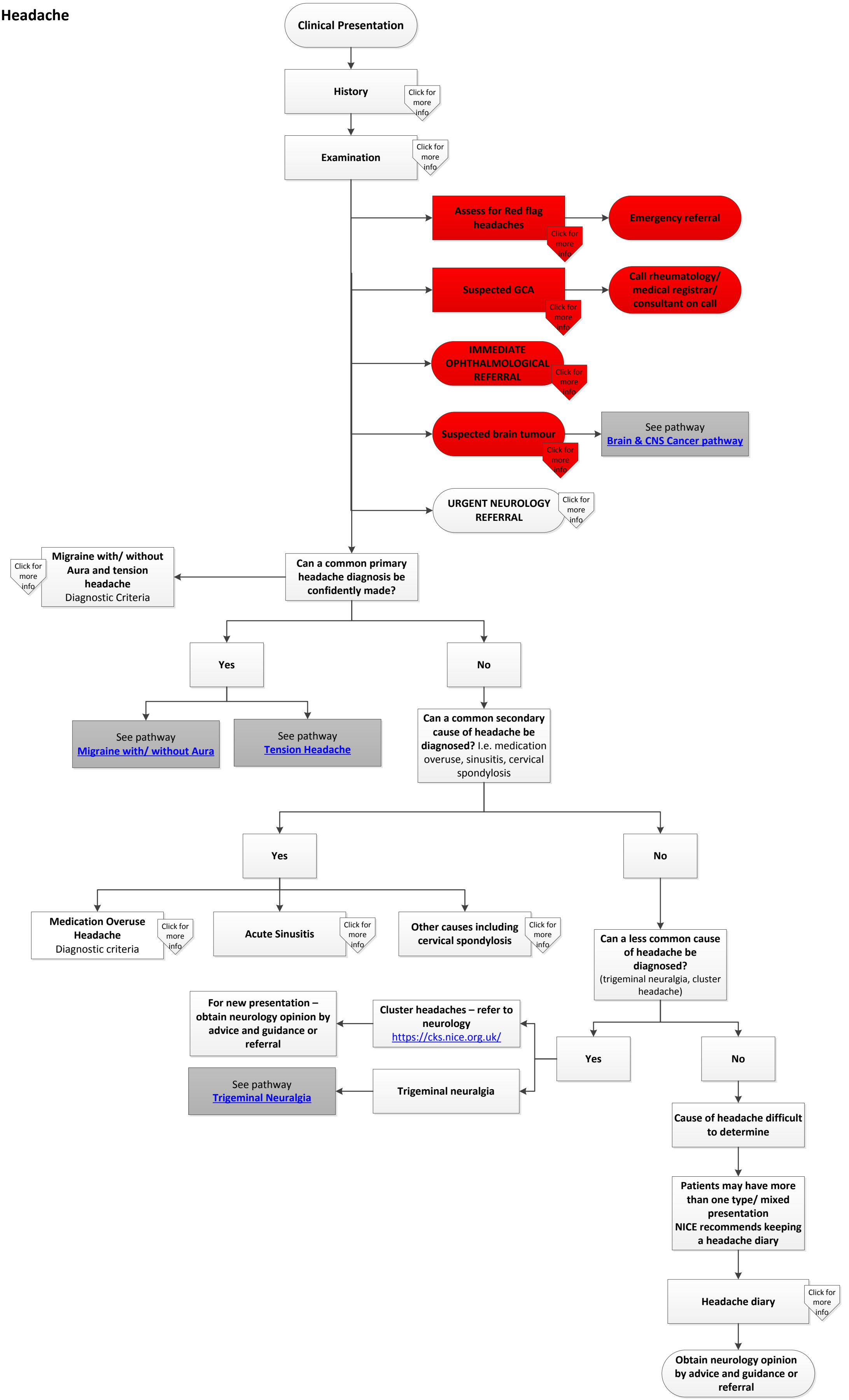
Headache


Clinical Presentation
History
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Examination
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Assess for Red flag headaches
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Emergency referral
Suspected GCA
Click for more info
Call rheumatology/ medical registrar/ consultant on call
IMMEDIATE OPHTHALMOLOGICAL REFERRAL
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Suspected brain tumour
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See pathway
Brain & CNS Cancer pathway
URGENT NEUROLOGY REFERRAL
Click for more info
Can a common primary headache diagnosis be confidently made?
Migraine with/ without Aura and tension headache
Diagnostic Criteria
Click for more info
Yes
No
See pathway
Migraine with/ without Aura
See pathway
Tension Headache
Can a common secondary cause of headache be diagnosed? I.e. medication overuse, sinusitis, cervical spondylosis
Yes
No
Medication Overuse Headache
Diagnostic criteria
Click for more info
Acute Sinusitis
Click for more info
Other causes including cervical spondylosis
Click for more info
Can a less common cause of headache be diagnosed?
(trigeminal neuralgia, cluster headache)
For new presentation – obtain neurology opinion by advice and guidance or referral
Cluster headaches – refer to neurology
https://cks.nice.org.uk/
Yes
No
See pathway
Trigeminal Neuralgia
Trigeminal neuralgia
Cause of headache difficult to determine
Patients may have more than one type/ mixed presentation
NICE recommends keeping a headache diary
Headache diary
Click for more info
Obtain neurology opinion by advice and guidance or referral

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History

Assessment of headaches can be complex and a specific headache diagnosis is usually based on the clinical history.

History to include:

- Onset, duration, frequency and temporal pattern (episodic, daily or unremitting).
- Pain characteristics including severity, site and spread of pain.
- Associated symptoms such as:
  - Aura (visual, auditory or gustatory disturbance), nausea, photophobia and intolerance of noise — may indicate migraine.
  - Autonomic features for example tearing, drooping or swollen eyelid, pain around one eye, nasal congestion or rhinorrhoea — may indicate cluster headache.
  - Systemic and neurological features such as fever, neck stiffness, weakness and visual disturbance.
  - Contacts with similar symptoms.
  - Consider possible carbon monoxide poisoning if household contacts or pets have similar symptoms.
- Precipitating and relieving factors such as:
  - Trauma, posture, Valsalva manoeuvres, fatigue or stress, menstrual cycle, and medication change or withdrawal.
- Comorbidities and past medical history including:
  - Compromised immunity, systemic illness, malignancy and pregnancy.
- Drug history including:
  - Drugs used for headache — intake, response to, and side effects of acute and preventive medications that have been tried.
  - Other prescribed and non-prescribed drugs such as anticoagulants, glucocorticoids, methamphetamines, and cocaine.
- Effect on activities — ask what does the person 'do' during attacks? For example
  - Migraine is associated with withdrawal from daily activities due to incapacity.
  - Tension-type headache typically has no effect on activities.
- Cluster headache is associated with agitation or restlessness.

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Examination

Examination should include:

- Vital signs
- Examination of extracranial structures- carotid arteries, temporal arteries, sinuses, Temporomandibular joints
- Neck
- Neurological examination- including fundoscopy

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RED FLAGS

- Onset of headaches >50 years
- Thunderclap headache- headache reaching maximum intensity within 5 minutes
- Progressive or persistent headache that has changed dramatically
- Persistent headache precipitated by valsalva manoeuvre (cough, sneeze, bending or exertion)
- Headache that worsens on lying down

Associated features:

- Meningism
- Papilloedema
- New-onset neurological deficit
- Seizures
- New-onset cognitive dysfunction
- Symptoms of temporal arteritis
- Red eye and haloes around lights (acute angle closure glaucoma)
- Immunosuppression or malignancy

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Suspected GCA

Suspect if:

- Headaches in >50's with a new onset localised headache (usually unilateral)
- Tenderness, thickening or nodularity of the temporal artery

Associated symptoms / features

- Fever, fatigue, anorexia, weight loss and depression
- Features of polymyalgia neuralgia
- Scalp tenderness, intermittent jaw claudication, neurological features
- **Visual disturbance – URGENT REFERRAL** – features usually permanent

Management

- Urgent ESR and CRP
- Refer to rheumatology/med reg on-call
- Start steroids immediately
- Visual symptoms start Prednisolone 60mg (to be seen by ophthalmology same day)
- Without visual symptoms – 40-60mg daily (minimum 0.75mg/kg)
- Start aspirin 75mg daily – unless it is contraindicated – seek specialist advise for duration
- Start PPI protection whilst on prednisolone

Whist awaiting review by specialist

- Review 48 hour – assess response to steroids

Advice to be given to the patient

- Seek urgent help (same day) if any visual disturbance occurs
- Prednisolone dose tapered very slowly – treatment often needed for 1-2 years

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IMMEDIATE OPHTHALMOLOGICAL REFERRAL

- Symptoms and signs of acute narrow-angle glaucoma - red eye and haloes around lights

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Suspected brain tumour - 2WW REFERRAL

- New onset headache in a patient with a history of HIV/ immunosuppression/ cancer (esp. if <20 years)

Clinical presentation of brain tumours tends to be related to the following:

- Focal/generalised seizures
- Progressive focal neurological deficits, such as:
- Gradual onset weakness or sensory loss on one side of the body
- Dysphasia
- Unilateral visual field loss

Headache:

- with cognitive, memory, or behavioural symptoms; or
- with features of raised intracranial pressure:
  - headache worse in the morning
  - nausea/vomiting
  - altered levels of consciousness, e.g. lethargy or somnolence in the early stages

Symptoms of a brain tumour are determined by its location and size

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URGENT NEUROLOGY REFERRAL

- Headache triggered by postural change (i.e. bending), cough, Valsalva manoeuvre or sneezing – suggestive of raised ICP
- New onset headache in a patient > 50 years (first or worst/unusual)
- Headache with atypical aura (duration >1 hour, or significant / prolonged motor weakness)
- Headache causing patient to wake from sleep

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Migraine Diagnostic Criteria

- Recurrent episodes of headache lasting between 4 and 72 hours untreated
- One or both of the following;
  - Nausea/vomiting
  - Photophobia/Phonophobia
- At least two of the following:
  - Site of pain: unilateral (bilateral in children)
  - Pulsating in character
  - Aggravated by routine physical activity
  - Moderate or severe in intensity

Tension Headache Diagnostic Criteria

Has two of the following criteria:

- Mild to moderate in severity
- Bilateral
- Pressure or tightening character
- Normal neurological examination
- Not aggravated by routine physical activity

Usually episodic pain lasting from 30 minutes to 7 day

Deemed chronic if occurs > 15 days per month

Can occur in combination with migraine and secondary headache triggers especially cervicogenic /neck problems

For Monthly and Annual Migraine and headache diary:

http://www.nationalmigrainecentre.org.uk/for-healthcare-professionals/migraine-and-headache-diary-2/?hilite=%22Monthly%22%2C%22migraine%22%2C%22diary%22

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Medication Overuse Headache

Diagnostic Criteria

- Headache is present on 15 days or more each month (for more than 3 months)

and

- Ergotamine, Triptans, opioids, ergots or combination analgesic medications on 10 days per month or more (for more than 3 months)

or

- Paracetamol, aspirin or an NSAID, either alone or any combination, on 15 days per month or more (for more than 3 months)

Link to CKS: https://cks.nice.org.uk/headache-medication-overuse

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Acute Sinusitis

Acute sinusitis usually follows a common cold, and is defined as an increase in symptoms after 5 days, or persistence of symptoms beyond 10 days, but less than 12 weeks.

In adults:

- Diagnose acute sinusitis by the presence of nasal blockage (obstruction/congestion) *or* discoloured nasal discharge (anterior/posterior nasal drip) *with* facial pain/pressure (or headache) and/or reduction (or loss) of the sense of smell.
  - Nasal blockage — usually bilateral and caused by rhinitis.
  - Facial pain/pressure — may be localized over the infected sinus, or it may affect teeth, the upper jaw, or other areas (such as the eye, side of face, forehead). Pain in the absence of other symptoms is unlikely to be sinusitis.

In children:

- Diagnose acute sinusitis by the presence of nasal blockage (obstruction/congestion) *or* discoloured nasal discharge (anterior/posterior nasal drip) *with* facial pain/pressure (or headache) and/or cough (daytime and night-time).
  - Facial pain is less prevalent in children.
  - There may also be ear discomfort (Eustachian tube blockage).

Suspect acute bacterial sinusitis when at least three of the following features are present:

- Discoloured or purulent discharge (with unilateral predominance).
- Severe local pain (with unilateral predominance).
- A fever greater than 38°C.
- A marked deterioration after an initial milder form of the illness (so-called 'double-sickening').
- Elevated ESR/CRP (although the practicality of this criterion is limited).

Diagnosis of chronic sinusitis

NB: Headache, whether episodic or chronic, should *not* be attributed to ***sinus disease*** in the absence of other symptoms suggestive of it. Chronic sinusitis is not a validated cause of headache unless there is an acute exacerbation.

How should I diagnose chronic sinusitis?
In adults:

- Diagnose chronic sinusitis by the presence of nasal blockage (obstruction/congestion) *or* nasal discharge (anterior/posterior nasal drip) *with* facial pain/pressure (or headache) and/or reduction (or loss) of the sense of smell, lasting for *longer* than 12 weeks without complete resolution.
- Compared with acute sinusitis, loss of smell is more commonly described, whereas facial pain is less common.

In children:

- Diagnose chronic sinusitis by the presence of nasal blockage (obstruction/congestion) *or* nasal discharge (anterior/posterior nasal drip) *with* facial pain/pressure (or headache) and/or cough (daytime and night-time), lasting for *longer* than 12 weeks.

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Other secondary causes of headache

Neck pain

- cervical spondylosis (headache may originate in neck usually neck stiffness and pain restriction in neck movement)
- acute torticollis
- cervical radiculopathy
- whiplash injury

Otitis media – acute or with effusion

Dental abscess

Caffeine withdrawal, in people consuming frequent caffeinated drinks such as tea, coffee, or colas

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Headache diary to include:

- Asking the person to record a headache diary, and reviewing this in a few weeks.
    - Diaries help to obtain an accurate description of symptoms necessary for diagnosis and may be particularly useful when symptoms are difficult to interpret due more than one type of headache disorder occurring in the same person.
    - The diary should record each episode of headache, its severity, duration, any triggers (including postural changes suggestive of raised intracranial pressure), associated symptoms, and use of analgesia and caffeinated drinks

A headache diary can be found in supporting documents - http://enhccg-web02/clinical-pathways/neurology/headache