Creating a healthy future for Buckinghamshire NHS

Buckinghamshire NHS Primary Care Trust

Headache Management Guidelines

Migraine/episodic tension type headache

Migraine is a common condition, although only a minority consult their GP

- 6% of men and 15% of women are affected
- Each GP is likely to see 5 new cases per year, and 40 consultations for existing migraine
- Therapy should be directed at the individual patients lifestyle and needs

There are some simple steps that can help patients with episodic headaches.

Diagnostic criteria:

Migraine:

1. Attacks last 4 - 72 hours
2. Headache has at least 2 of the following
   - Unilateral
   - Pulsating
   - moderate to severe intensity
   - aggravated by a activities
3. Accompanying symptoms include phonophobia, photophobia, nausea either with or without vomiting
4. Patients are symptom free between attacks.

Episodic tension type criteria:

1. Attacks last 30 minutes to 7 days.
2. No nausea, vomiting, phonophobia or photophobia (although some nausea is not uncommon)
3. Headache has at least 2 of the following:
   - non-pulsating
   - mild to moderate
   - bilateral
   - not aggravated by activity.

Triggers: (see patient brochure)

- Stress
- Change in habit - missing meals, changing sleep pattern.
- Strong smells
- Hormonal changes.

- Food and drink (chocolate, cheese, alcohol, citrus fruits, caffeine)

Acute Treatments:

Goals

- Restore the patient's ability to function
- Treat attacks effectively, rapidly and consistently to minimize adverse events.
- Minimize the need for back-up and rescue medications
- Optimize self care and reduce subsequent use of resources

Principles

- Act promptly. Failure to use an effective treatment promptly may increase pain, disability and impact of the headache.
- Select a non-oral route for patients with associated severe nausea and vomiting
- Do not restrict anti-emetics to patients who vomit or are likely to vomit
- Guard against medication-overuse headache ("rebound headache"). Limit acute therapy to two days per week.
- Do not persist with an ineffective option. Try an alternative; in most patients it is possible to find an effective acute treatment.

Medication Options:

1. Simple analgesic:

   a) consider adding an anti-emetic

   b) consider a higher than usual dose e.g aspirin 900mg or paracetamol 1.5 g.

   - Best taken early in the attack when absorption may be less inhibited by gastric stasis.
   - In some patients, it is preferable to take the anti-emetic 20 - 30 minutes before the analgesic.
   - Soluble preparations are preferable
   - Combinations of simple analgesics with anti-emetic formulations can be used as an alternative to prescribing individual drugs. Some have been shown to have comparable efficacy to sumatriptan, and, may

even have some advantages over sumatriptan.

- If vomiting is a problem try rectal paracetamol or rectal diclofenac along with rectal domperidone.

2. Non-steroidal agents. These are worth trying if there is no success with the above. There still may be benefit from an anti-emetic in some patients. Ibuprofen (600 to 900mg), flurbioprofen, diclofenac, tolfenamic acid and naproxen are all licenced for migraine.

3. Triptans.

- As with any drug, patients may vary in their response; if a patient fails to respond to one triptan, it is worth trying an alternative
- An anti-emetic can still be used if necessary.
- Contra-indicated in patients over 65 and patients with known vascular disease (stroke, TIA, MI, angina) as is ergotamine

Rescue Options

- First choice is rectal anti-emetic (rectal domperidone) and rectal diclofenac acid.
- Intramuscular diclofenac 75 mg
- Intramuscular chlorpromazine 25 - 50 mg.

<u>Preventive Management</u>

Consider for:

- **frequent headaches (> 1 per week)**
- migraines that significantly interfere with patient's daily routines, despite acute treatment
- contra-indication to, failure of or adverse effects from acute therapies
- patient preference

Principles

- an effective drug should be used for 4 - 6 months before attempting withdrawal

- a minimum of a month trial is recommended before discontinuing a preventive drug as ineffective
- can base choice on comorbidity and contra-indications (e.g. beta blocker if concomitant hypertension, tricyclic agent if concomitant sleep disturbance)
- a patient diary can be a useful way of assessing effectiveness.

Medication Options:

- Beta blocker: atenolol 25 mg od to 100 mg bd; propranolol-LA 80 mg to 320 mg od.
- Tricyclic agent: amitriptyline 10 - 150 mg daily (If there is excessive sedation with amitriptyline, try one or two alternative tricyclic agents)
- Pizotifen 1.5 mg daily
- Sodium valproate 0.6 - 2.5 g daily; should not be used in pregnancy or if contemplated.
- Topiramate 100 mg daily; needs to be titrated gradually (25 mg increases every 2 weeks)

Chronic Daily Headache

- this is a descriptive term, not a diagnosis, defined as headache>15 days per month
- mixture of
  - chronic tension-type headache
  - depression
  - cervicogenic headache
  - medication overuse (particularly codeine)
  - giant cell arteritis (age >50 years)

Suggestions for management

- Neurological examination - if focal abnormalities patient will need referral and imaging
- ensure patient is not overusing medications (even paracetamol may cause

rebound headaches)

- restrict analgesic or other acute treatments, including triptans, to no more than 2 days per week
- a several week trial of a non-steroidal agent e.g. naproxen 500 mg twice daily is recommended first option
- Consider any of the other prophylactic medications listed under migraine.

Serious Headaches:

Temporal arteritis

- Consider in older patient with new headache
- jaw claudication, scalp tenderness and non-specific malaise are clues to diagnosis
- weight loss
- check e.s.r/CRP

Subarachnoid haemorrhage

- Consider if sudden onset severe headache
- Usually will have neck stiffness
- may have alteration in consciousness at time of onset
- if suspected should be referred to A&E for CT scan and LP as a medical emergency.

New onset headaches with fever and mental status changes

- Consider meningitis
- Refer to A&E for evaluation as a medical emergency.

Progressive neurological deficit

- Refer to neurology for urgent imaging.

Imaging and headache

- Headache as the sole presentation of brain tumour is very rare
- The American Academy of Neurology guidelines state: "in adult patients with recurrent headaches that have been defined as migraine, including those with no visual aura, with no recent change in pattern, no history of seizures and no other focal neurologic signs or symptoms, the routine use of neuroimaging is not warranted."
- In a review of 1600 CT and MRI scans with various types of headache, other than white matter abnormalities, only 4 brain tumours were found, 3 of which were incidental findings, and there was one arteriovenous malformation.
- Audit at Stoke Mandeville of scans requested by the neurology service at Stoke Mandeville Hospital (i.e. referred by the neurologist) found 10 abnormalities out of 515 patients. 8 of these were irrelevant. There were 2 tumours. Neither of these two patients met the criteria for migraine or tension-type headache.
    - for comparison, in epilepsy, a tumour is found in about 3% of patients, and in suspected stroke, about 4%
    - Only 16% of patients with brain tumour had headache as part of their presentation

<u>Resources and references:</u>

Professional:

www.bash.org.uk/

www.ahsnet.org

www.i-h-s.org

www.aan.com

www.ion.bpmf.ac.uk/-headache/headache.html

Patient resources:

www.migrainetrust.org/

www.migraine.org.uk/

www.achenet.org/

www.clusterheadaches.org.uk/

www.clusterheadaches.com