Headache and the remote consultation

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GPwSI Headache South Eastern Trust, Northern Ireland

Disclosures

- I have received honoraria from the following companies for providing educational sessions and to attend conferences
  - Allergan
  - TEVA
- Trustee of the Migraine Trust
- BASH Council Member 2015-2019

The role of the GP is to accept uncertainty, to explore probability and to marginalise danger”
Marinker, 1998

“The role of the specialist is to reduce uncertainty, to explore possibility and to marginalise error”

Aims of this session

- Outline features of secondary headache to aid safe telephone triage and consultation
- Overview of some not-to-miss diagnoses
- Signpost to useful resources for primary care
- Lots of time for Q+A

How big is the problem of headache?

- 3% of adults in UK visit their GP with headache each year
- GPs manage 97% of headache consulters without referring to a specialist
- GPs refer 2% of headache consulters to neurology
- 25-33% of NEW appointments to neurology are for headache

Latinovic et all, JNNP 2006:77:385-7

What do people with headache who see their GP actually have?

Estimates of diagnoses in primary care, Landmark study, Kernick 2008

Diagnosis	% of consultations
Migraine	73%
Other primary headache (predominantly “tension type”)	23%
Sub-arachnoid haemorrhage	0.05%
Meningitis	0.02%
Temporal Arteritis	0.02%
Primary Tumour	0.09%

Migraine is the most common headache diagnosis in primary care but how commonly is it actually diagnosed?

Telephone triage/consultation

EXCLUDE A SECONDARY HEADACHE

- Do something now
- Do something soon

- DIAGNOSE A PRIMARY HEADACHE
- Exclude medication overuse and manage the primary headache

S – headache with Systemic features. Secondary RF (eg HIV, cancer, trauma)	Fever, rash, neck stiffness, weight loss, malaise, personality changes GCA, meningitis, encephalitis, CVD, cancer
Neurological signs/symptoms	Features not in keeping w aura CNS infection, stroke, AVM, bleed
Onset is sudden/abrupt (<5min)	Bleed, mass lesion
Older than 50 years old (new)	Think ESR, imaging. GCA, PMR, Mass lesion
Positional, valsalva	SIH, IIH, post fossa mass, chiari
Prior headache (now different/progressive)	MOH, mass, subdural haematoma
Papilloedema, Visual problems	?mass ?intracranial hypertension or infection

History is (almost) everything

- The golden 60 seconds
- ICE – Why are they consulting now?
- What were you doing when the headache came on?
- Context
- Feel heard (therapeutic)

How does temporal pattern help differentiate between primary and secondary?

- Sudden onset headache reaching max intensity ≤ 5 minutes.
  - Greatest probability of secondary precipitant

- Recent onset and progressive headache
  - Evolution over days/weeks. If associated systemic features and/or focal neurological signs there is an increased probability of secondary precipitant.

- Recurrent episodic headache
  - In isolation – most likely primary headache

- Headache which occurs on the majority of days in a month
  - If >15days/months for >3 months in isolation is most likely primary headache disorder.

Focused

Eyes

Neck

Gait, coordination

Plantars

BP

?temporal artery

?fever assessment

?neck – cervical flexion rotation test

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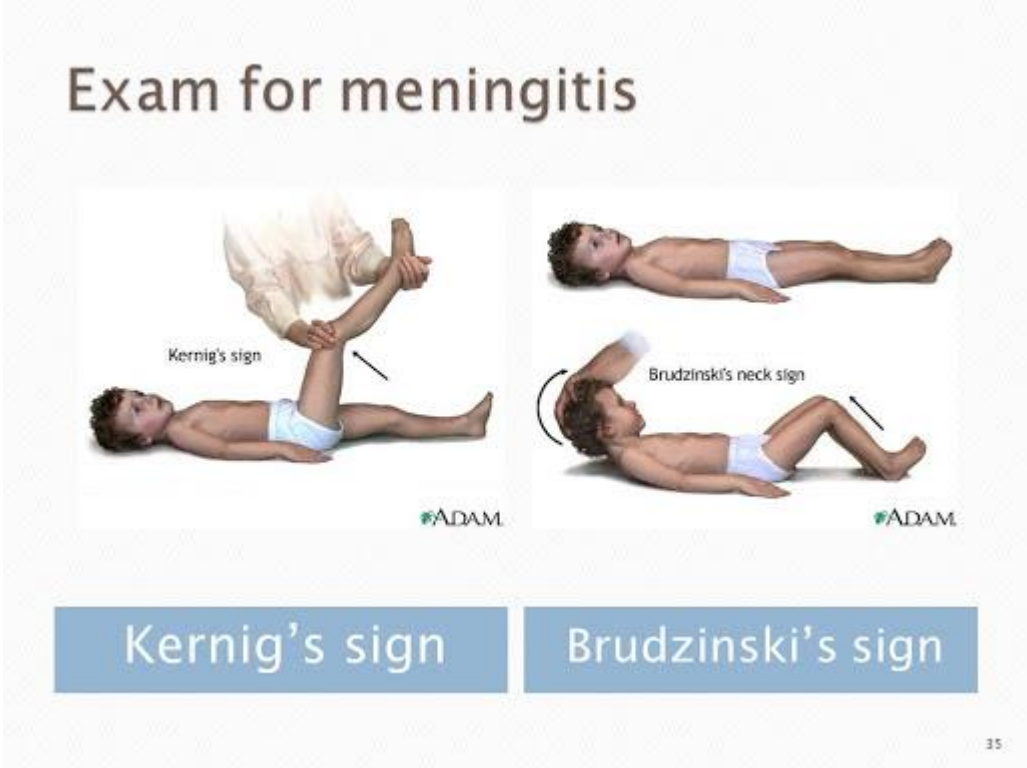
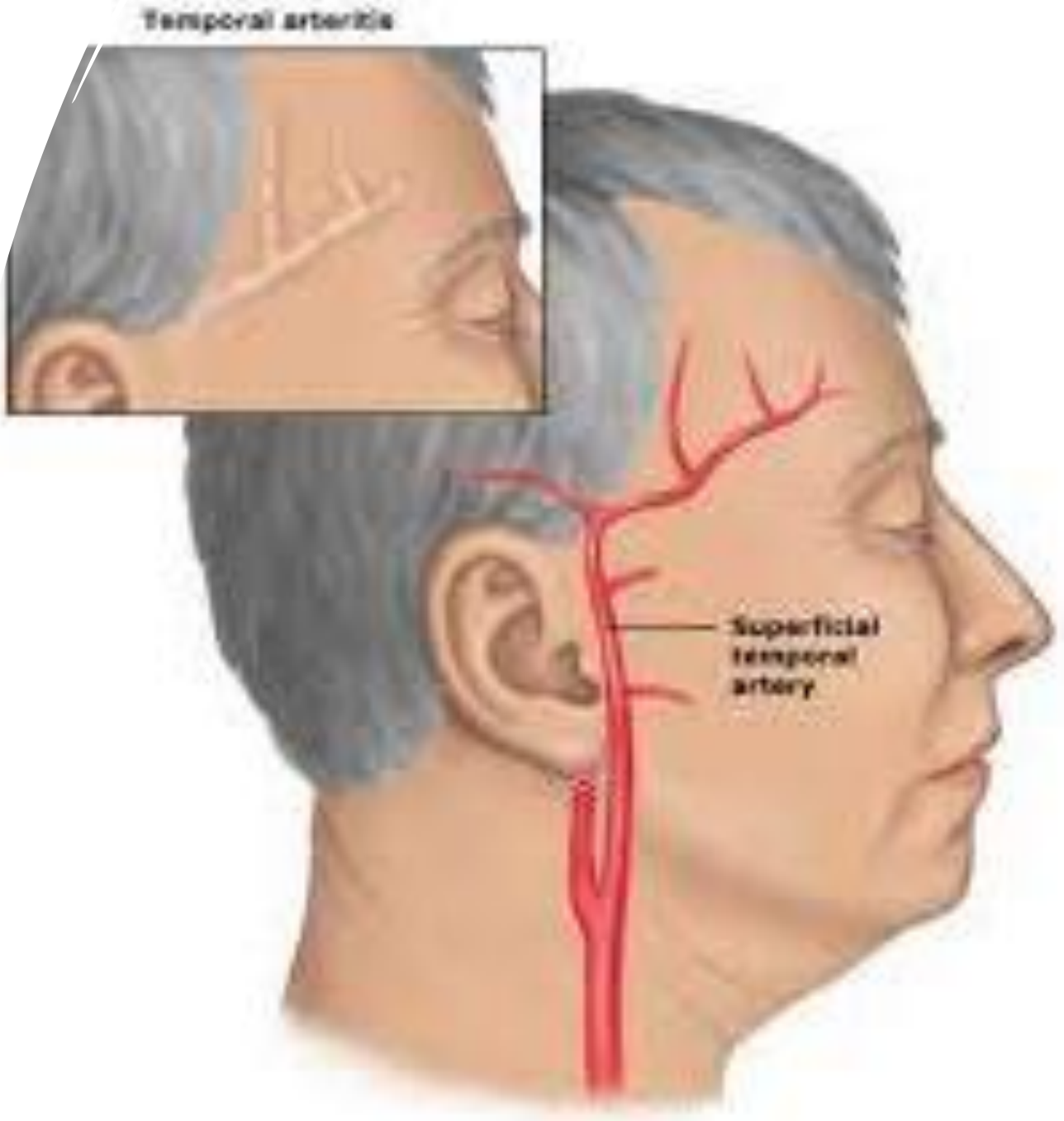
New Onset Headache & Fever

Systemic Illness
Headache
Paranasal Sinusitis
Meningitis – viral
Meningitis – bacterial
Encephalitis

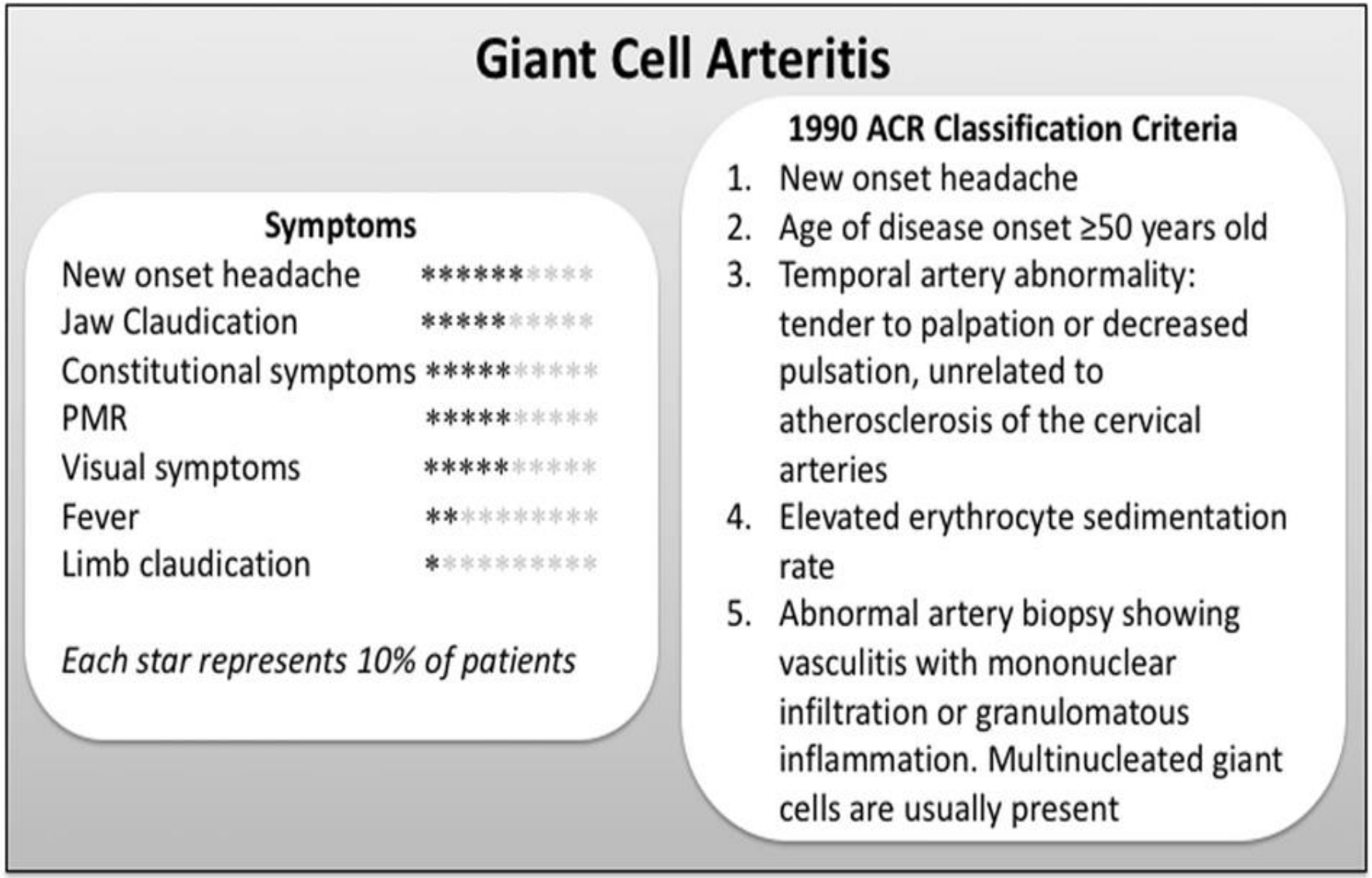


Giant Cell Arteritis

- Big concern:
- Arteritic Anterior Ischaemic Optic Neuropathy
- Sudden, painless and profound visual loss in one or both eyes
- Visual loss occurs in up to 20% of pts before steroid therapy



From: A new era for giant cell arteritis



Eye
(*Eye*) ISSN 1476-5454 (online)

Diagram of frequency of symptoms of GCA and the American College of Rheumatology (ACR) 1990 criteria for the definite diagnosis of GCA [30, 100, 101]

GCA

GP check **ESR, CRP, BP**

Do not delay high dose oral steroids if clinical suspicion is high

If ophthalmological symptoms – ophthalmology same day

Otherwise rheumatology same day if possible and within 3 days

Rheumatology, Volume 59, Issue 3, March 2020, Pages e1–e23to

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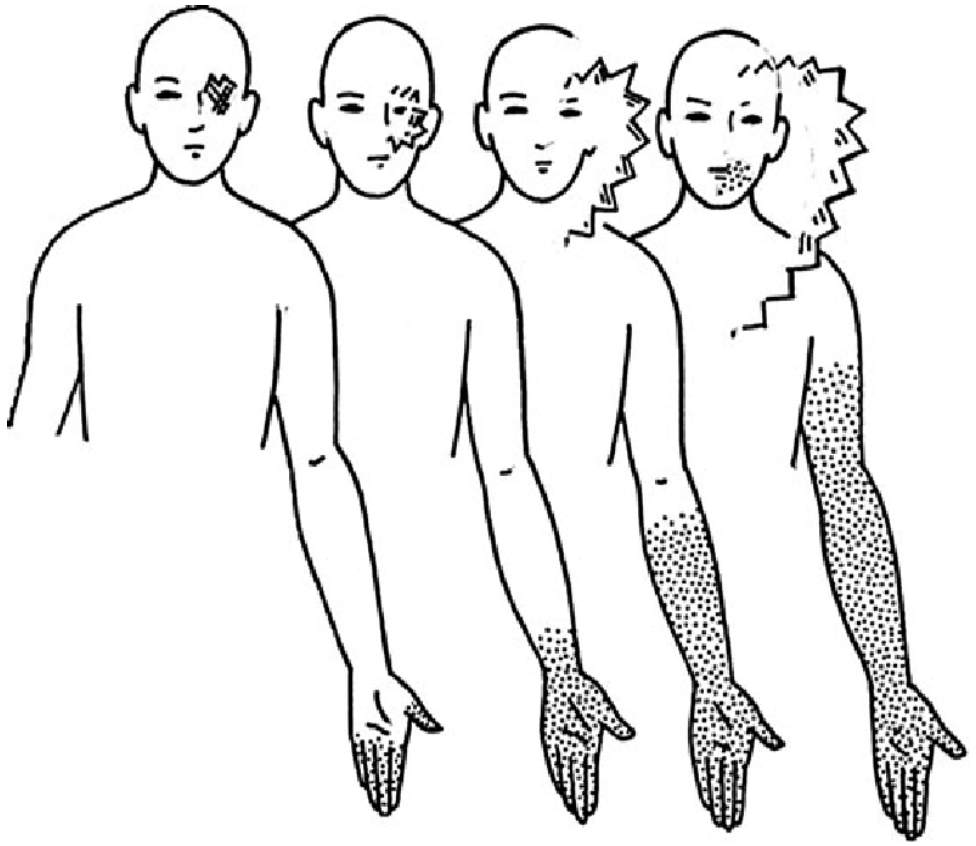
Focal Neurological Deficit (not aura)

- Aura is in about 1/3 migraine sufferers
- 5-60 mins
- Gradually develops, fully resolves

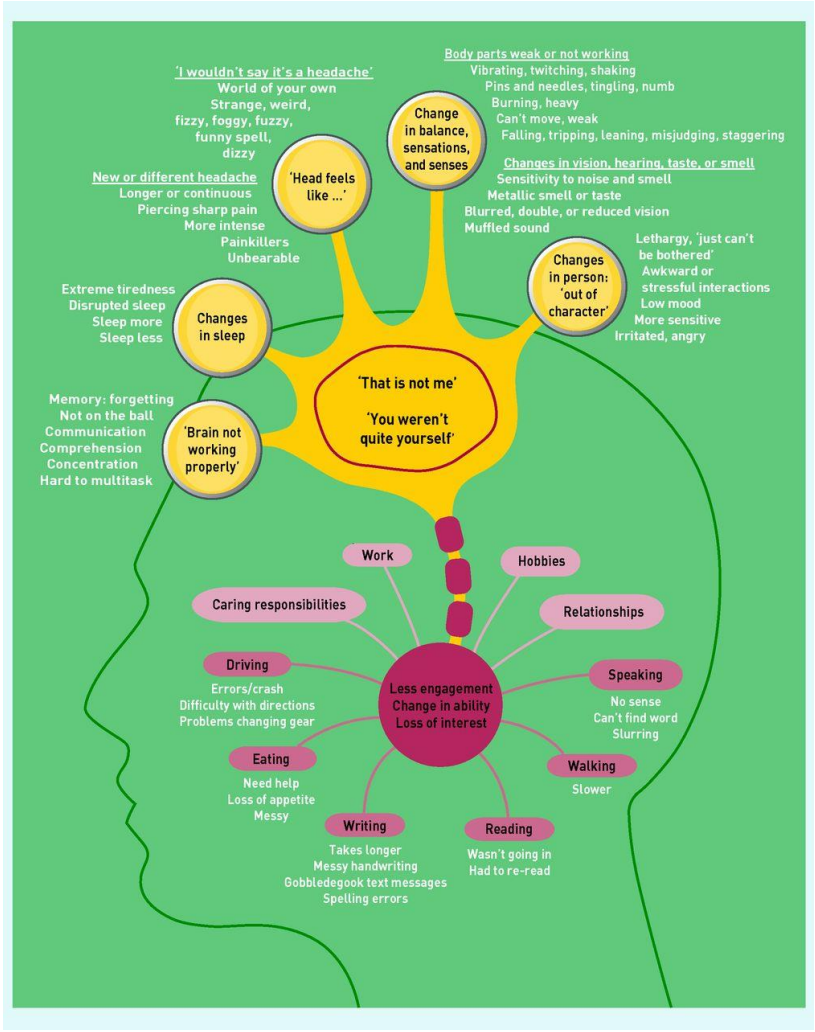
- Brain tumour red flags: papilloedema, seizure, significant alteration in consciousness, speech disturbance, coordination probs, hx of ca



Amaurosis Fugax – NOT migraine

- Transient monocular or binocular visual loss
- 2-30 mins
- Entire visual field or partial
- Risk of hemispheric stroke 2% per year
- Risk factors:
  - >50
  - RF for CVD hypertension, smoking, hyperlipidaemia, obesity, FH, diabetes, use of cocaine

Changes or symptoms experienced by participants before their brain tumour diagnosis.



Fiona M Walter et al. Br J Gen Pract 2019;69:e224-e235

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BJGP British Journal of General Practice
bringing research to clinical practice

ORIGINAL RESEARCH Clinical Medicine 2021 Vol 21, No 6: e648–55

Isolated headache is not a reliable indicator for brain cancer: the 2-week wait pathway for suspected CNS malignancies

Authors: Bryan Ceronie,[A] Thomas Hart,[A] Daniel Belete,[B] Lucille Ramani[C] and Anish Bahra[D]

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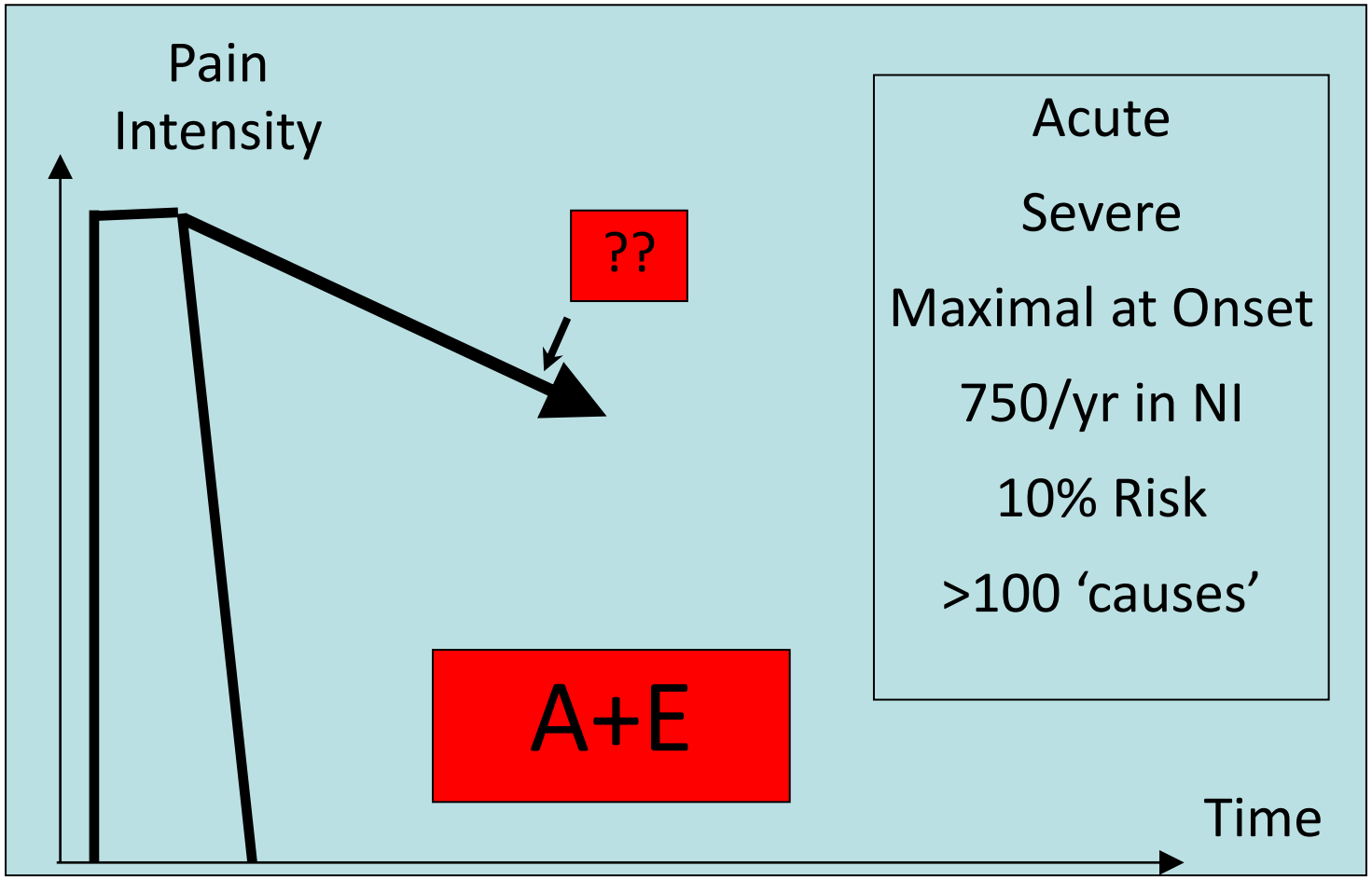
‘Thunderclap’



Practice Tip:

“From the start of your headache until it reached its peak - how long did it take?”

Is it OK if it is recurrent?

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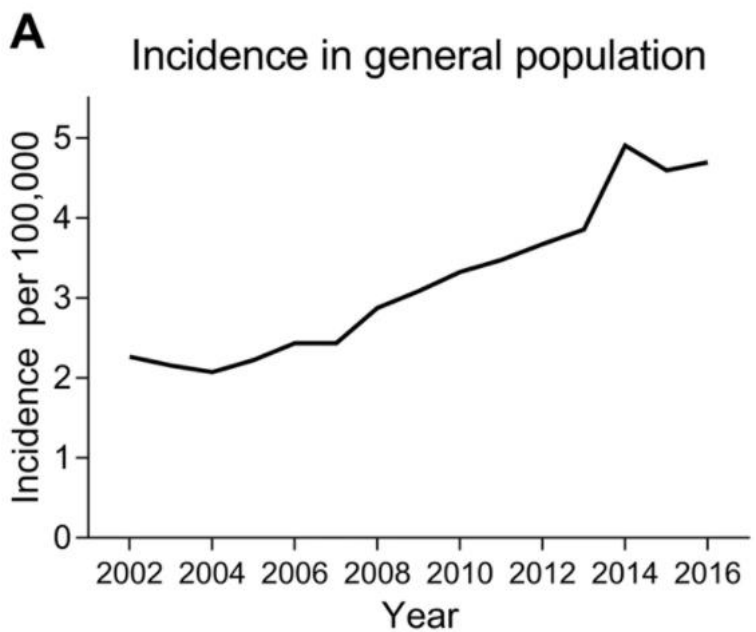
Article | Open Access | Published: 24 October 2018

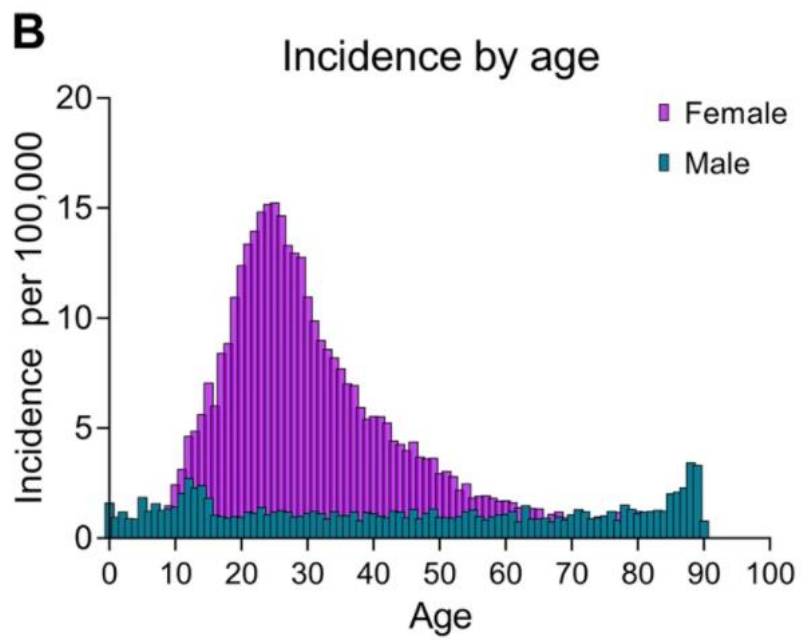
The expanding burden of idiopathic intracranial hypertension

Susan P. Mollan ✉, Magda Aguiar, Felicity Evison, Emma Frew & Alexandra J. Sinclair

Eye **33**, 478–485 (2019) | Cite this article

4776 Accesses | **76** Citations | **43** Altmetric | Metrics





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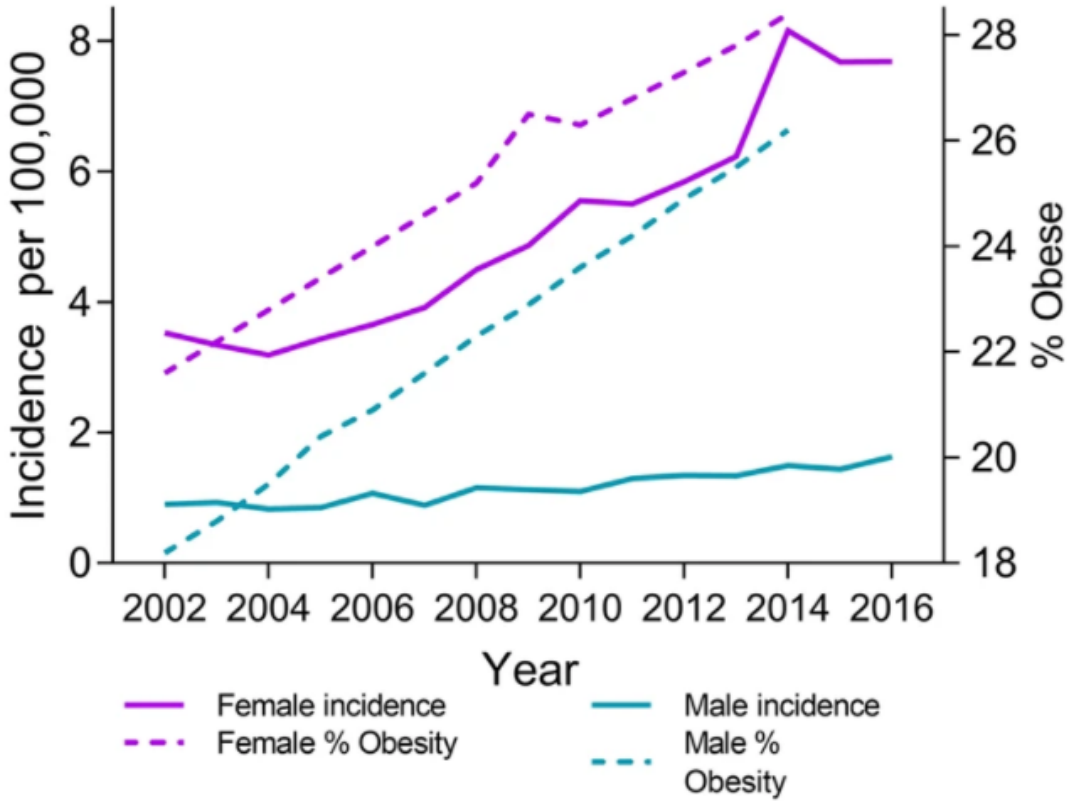
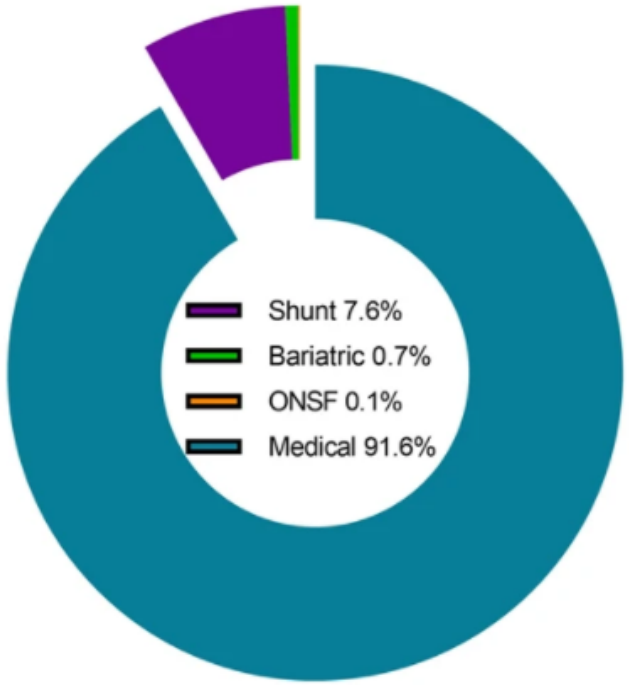

Incidence and obesity rates
Incidence per 100,000
% Obese
0
2
4
6
8
18
20
22
24
26
28
2002 2004 2006 2008 2010 2012 2014 2016
Year
Female incidence
Female % Obesity
Male incidence
Male % Obesity

D

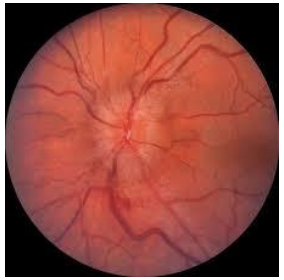

Management
Shunt 7.6%
Bariatric 0.7%
ONSF 0.1%
Medical 91.6%

Up to a 25% of people with IIH will experience permanent visual impairment

Fundoscopy

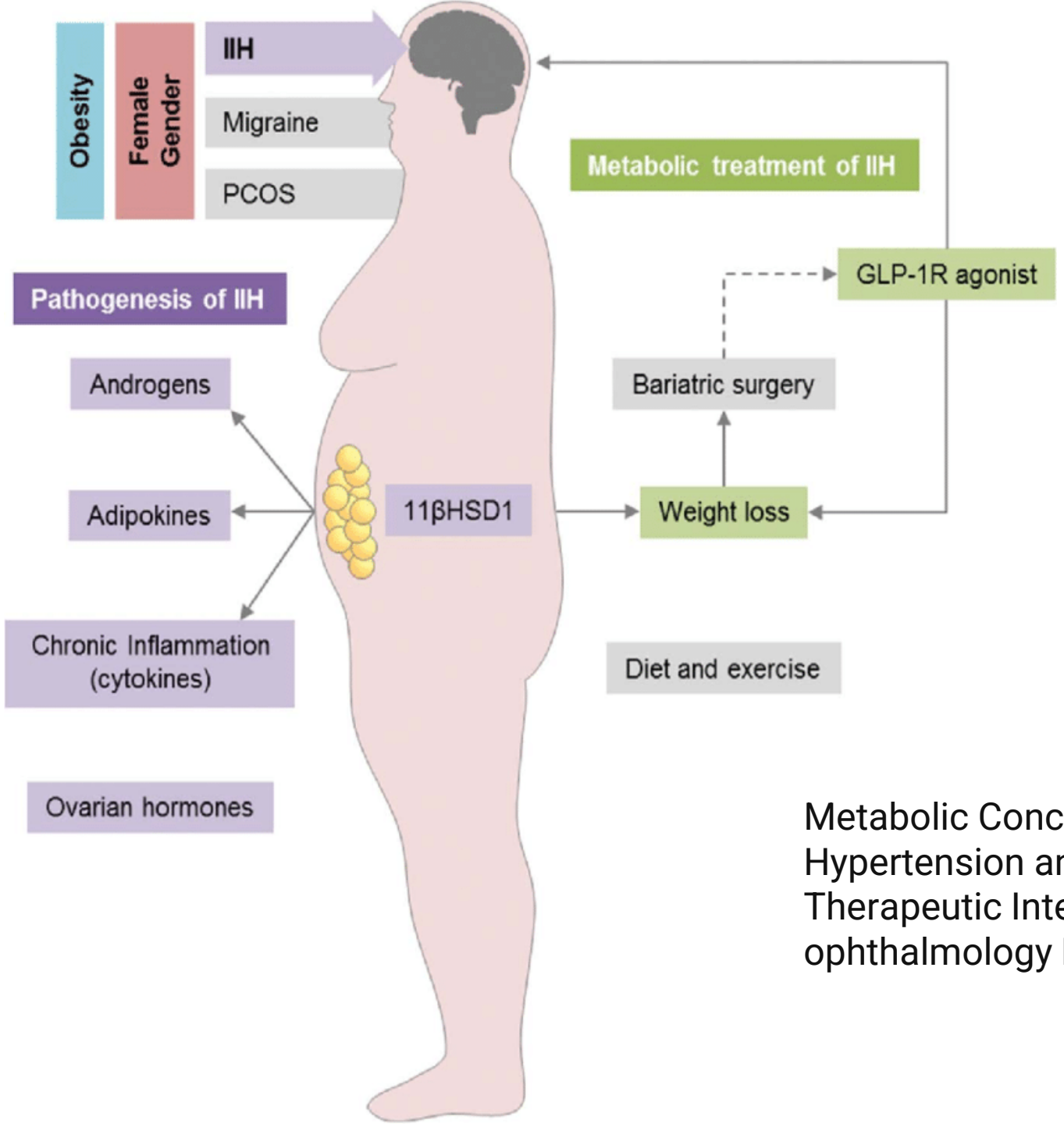
Idiopathic Intracranial Hypertension

- Headache often migrainous features; ask about Valsalva/ICP; TVO
- Young, obese female
- Papilloedema



- Vitamin A toxicity, cOCP, steroids, tetracyclines
- Diplopia, VI nerve palsy, abnormal visual fields

Referral to ED if first presentation (as current neurology urgent waiting times long)



Metabolic Concepts in Idiopathic Intracranial Hypertension and Their Potential for Therapeutic Intervention Journal of ophthalmology Markey et al 2016

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The most consistent indicators for serious secondary headache are:

- Thunderclap (sudden onset) headache
- Associated focal neurological deficit
- Associated systemic features
- Patients over the age over 50 years

BASH
BRITISH ASSOCIATION FOR THE STUDY OF HEADACHE

HEADACHE
The Journal of Head and Face Pain

RESEARCH SUBMISSIONS

Green Flags and headache: A concept study using the Delphi method

Heiko Pohl MD, Thien Phu Do MD, David García-Azorín MD, MSci, Jakob Møller Hansen MD, PhD, MSc, Espen Saxhaug Kristoffersen MD, PhD, Sarah E. Nelson MD ... See all authors

First published: 06 January 2021 | https://doi.org/10.1111/head.14054

Migraine Screening Questionnaire

1. Do you have frequent or intense headaches?
2. Do our headaches usually last more than 4 hours?
3. Do you usually suffer from nausea when you have a headache?
4. Does light or sound bother you when you have a headache?
5. Does headache limit any of your physical or intellectual abilities?

Differs from Cluster Headache in that

- Peri-orbital pain up to 3 hours
- Unilateral autonomic features
- RESTLESS
- High impact
- Needs subcutaneous sumatriptan 6mg
- Refer specialist

Time – our greatest enemy or most powerful tool?

Chronic headache first consultation

- History, get them to tell you about the **worst** headache
- **Ask** about migraine features
- What do you do when you get a headache? Number of days/week taking meds?
- Minimum examination – Fundi and BP
- Diary
- Review in 4 weeks

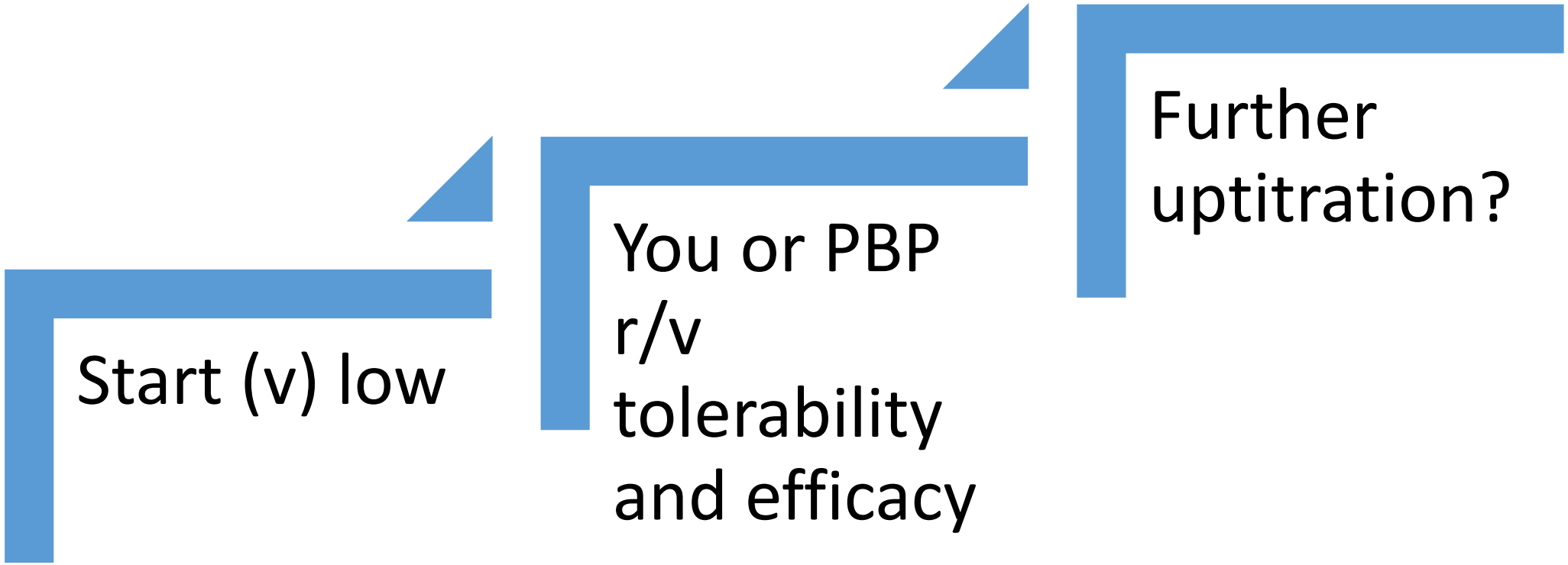
Second consultation

- Review history, diary
- Think about what is driving the headache – sleep, caffeine, anxiety
- Further examination? Have they had fundi checked? Focal neurological exam. Neck
- Bloods if not settling eg FBP, LFT, TFT, iron
- Address MOH, commence prophylaxis, diary
- Review 4 weeks

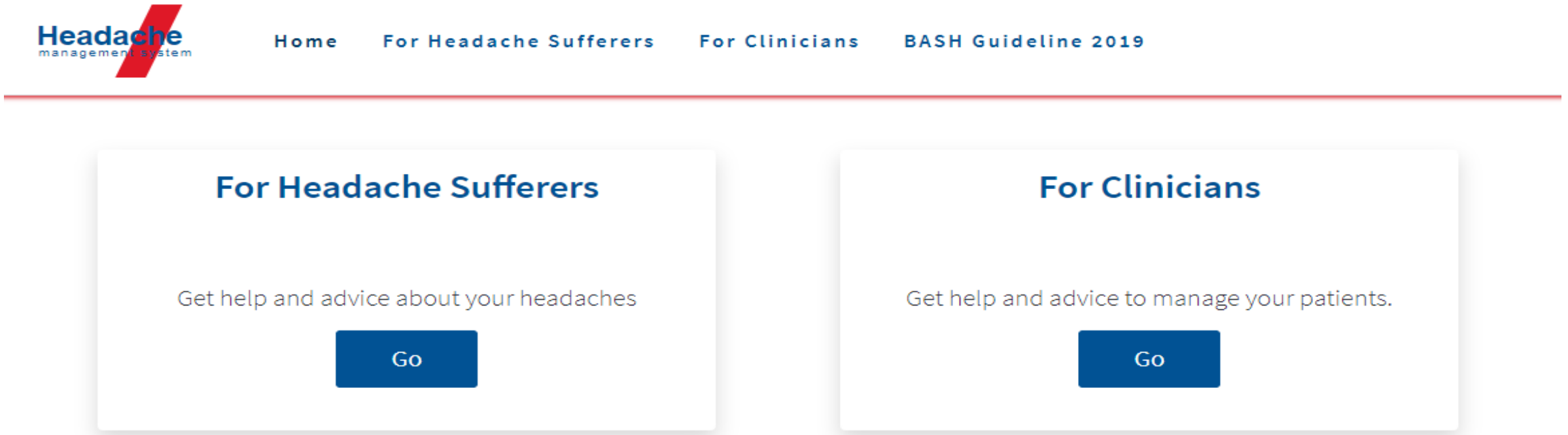
Now 8 weeks from first presentation

- What is the pattern of the headaches?
- Can you diagnose primary headache? Is there anything concerning?
- Examine at this apt if haven’t at the second
- If can’t diagnose primary headache have a discussion about imaging

Prophylaxis also in 4 week steps



https://headache.org.uk/



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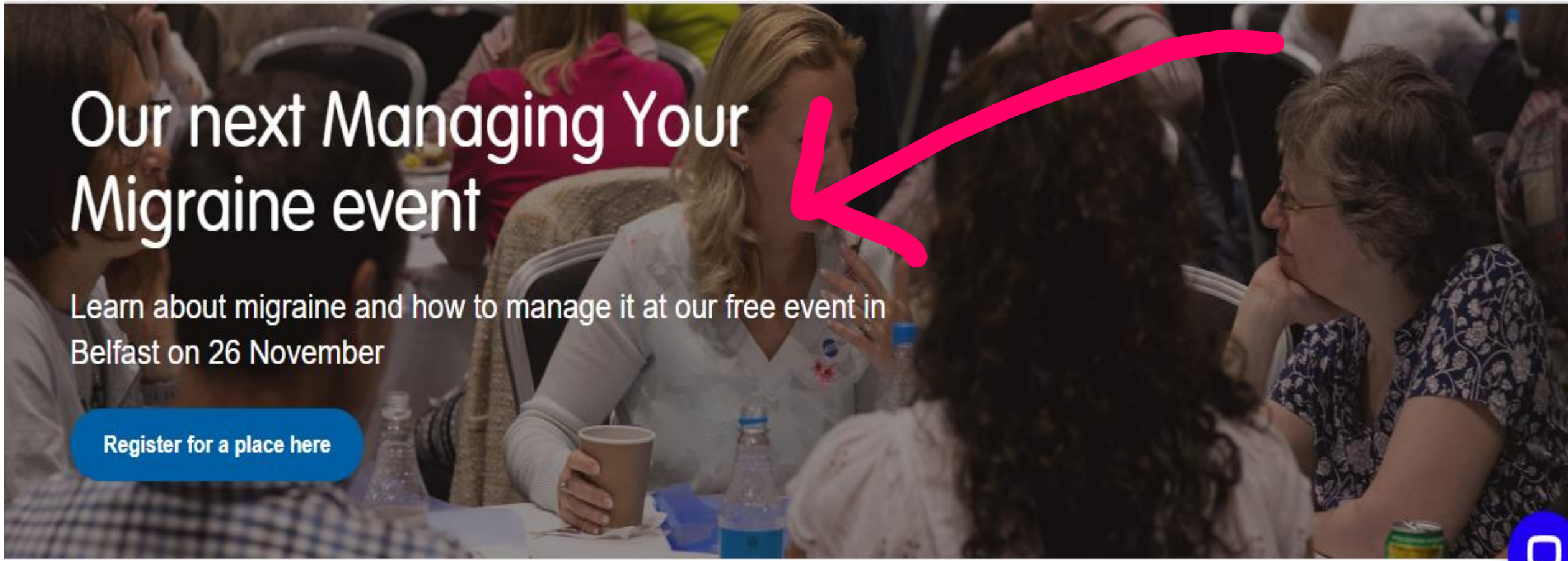


What non-pharmacological options are there which have evidence of efficacy for management of vasomotor symptoms and prophylaxis of migraine?

- Regular exercise
- Weight loss

What pharmacological options are there which have evidence of efficacy for management of vasomotor symptoms and prophylaxis of migraine?

Treatment		Dose
Hormonal		
Post hysterectomy	Continuous transdermal estrogen	Lowest estrogen dose required to control vasomotor symtoms
Uterus intact: premenopause	Continuous transdermal estrogen plus LNG-IUS	
Uterus intact: postmenopause	– Continuous transdermal estrogen plus LNG-IUS – Continuous combined estrogen/ progestogen patches – Continuous transdermal estrogen plus micronized progesterone – Tibolone	
Non-hormonal		
SSRIs	Escitalopram	10-20 mg/day
SNRIs	Venlafaxine	37.5-150 mg/day

LNG-IUS, levonorgestrel intrauterine system; SSRI, selective serotonin reuptake inhibitor; SNRI, serotonin norepinephrine reuptake inhibitor.

Resources

For healthcare professionals – www.thebms.org.uk
www.bash.org.uk

For women – www.womens-health-concern.org
www.menopausematters.co.uk
www.managemymenopause.co.uk

www.bms.org.uk

Suspected neurological conditions: recognition and referral

NICE guideline [NG127] Published: 01 May 2019 Last updated: 04 July 2019

Recommendations for children aged under 16
Terms used in this guideline
Rationale: recommendations for adults aged over 16
Rationale: recommendations for children aged under 16
Context
Finding more information and committee details
Update information

Recommendations for adults aged over 16

1.1 Blackouts in adults
1.2 Dizziness and vertigo in adults
1.3 Facial pain, atraumatic
1.4 Gait unsteadiness
1.5 Handwriting difficulties
1.6 Headaches in adults
1.7 Limb or facial weakness in adults
1.8 Memory failure and cognitive deterioration
1.9 Posture distortion in adults
1.10 Sensory symptoms including tingling or numbness in adults
1.11 Sleep disorders in adults
1.12 Smell or taste problems
1.13 Speech, swallowing and language problems in adults
1.14 Tics and involuntary movements in adults
1.15 Tremor in adults
1.16 Information and support

1.15 Tremor in adults

Tremor suggesting Parkinson's disease

1.15.1 Refer adults with suspected parkinsonian tremor, other asymmetric tremor, or tremor associated with stiffness, slowness, balance problems or gait disorders for neurological assessment before treatment, in line with the NICE guideline on Parkinson's disease in adults.

Essential tremor

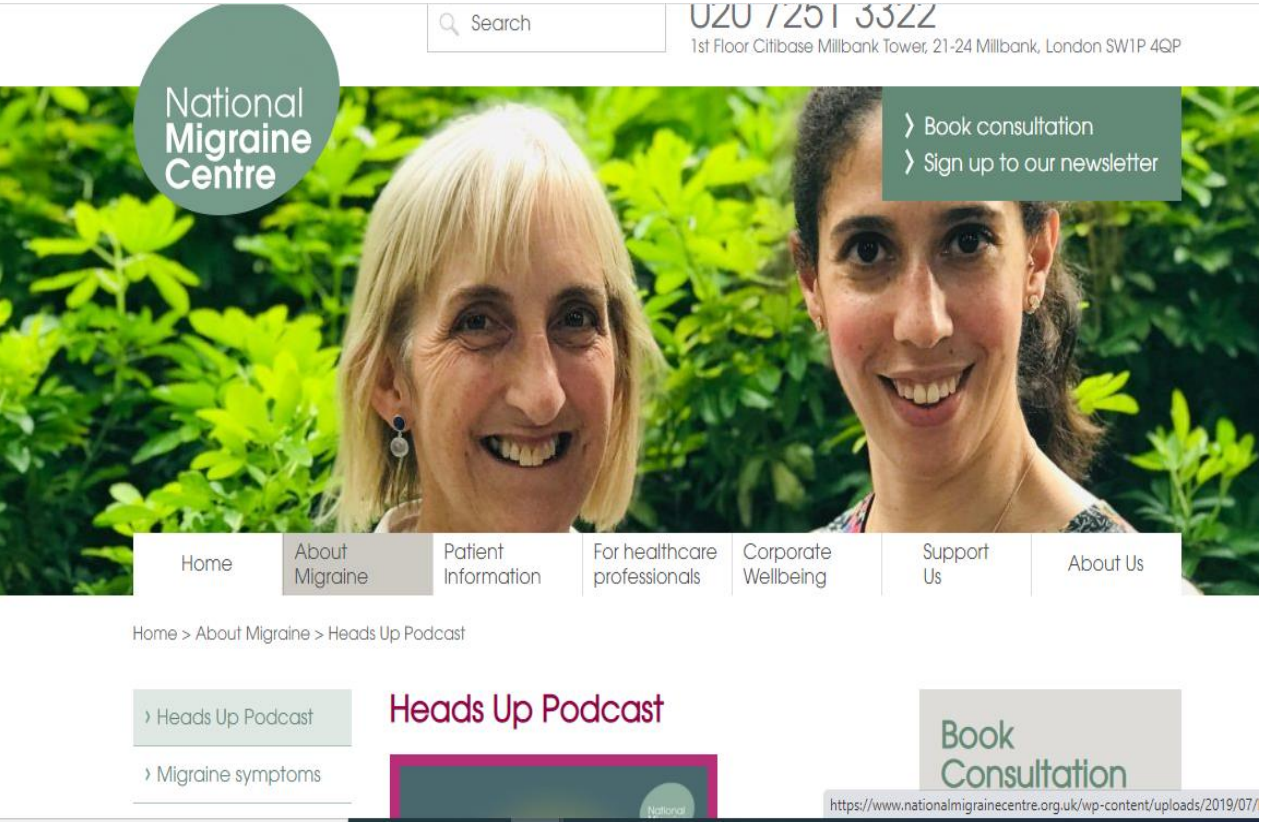
1.15.2 Suspect essential tremor in an adult with symmetrical postural tremor and no symptoms of parkinsonism.

1.15.3 In adults with suspected essential tremor:

- review regular medication
- check thyroid function
- assess alcohol consumption using a tool such as AUDIT (Alcohol Use Disorders Identification Test), in line with the NICE guideline on alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.

Essential tremor

https://www.nationalmigrainecentre.org.uk/migraine-and-headaches/heads-up-podcast/



- Hormones
- Acute/preventatives
- MOH
- Migraine and men
- Self management
- Workplace
- Sleep

Thank You