

HEADACHE – COMMON AND IMPORTANT PRESENTATIONS

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- ▶ One of the most common neurological symptoms
- ▶ Account for 30% GP and 50% Neurology Referrals
- ▶ 95% of the population at some stage experience headaches
- ▶ 15-19% of Acute Medical Admissions(1), 55% of Neurology in A&E(2)

1. Weatherall M., J RCP Edinb 2006; 36: 196-200

2. Craig J., Patterson V., Roche L., Jamison J., Accident and Emergency Neurology: time for a reappraisal? Health Trends, 1997, 29, 89-91

WHY IS HEADACHE IMPORTANT?

- ▶ International Classification of Headache Disorders lists 338 different headache syndromes.
- ▶ A practical approach is to split headache into Primary and Secondary headache syndromes.
- ▶ Primary headache includes migraine, tension type, cluster and the autonomic cephalalgias.
- ▶ Secondary headache includes SAH, RCVS, CVST, IIH, infections and space occupying lesions

HOW IS HEADACHE CLASSIFIED?

▶ In a large (n=97,000) study patients presenting with headache were followed up to find the ultimate diagnosis

▶ Secondary headache	5%
▶ Tension Headache	21%
▶ Migraine	72%
▶ Cluster	2%

HOW DOES HEADACHE
BREAKDOWN?



- ▶ Eight million people in UK suffer from migraine
- ▶ More prevalent than diabetes, epilepsy and asthma combined
- ▶ Severe migraine attacks are classified by the World Health Organisation as among the most disabling illnesses, comparable to dementia, quadriplegia and active psychosis (Shapiro & Goadsby, Cephalalgia, September 2007)
- ▶ Just over a third (34.3%) of migraine sufferers face difficulties or discrimination at work because of their condition (The Migraine Trust, 2004)
- ▶ Migraine remains undiagnosed and undertreated in at least 50% of patients, and less than 50% of migraine patients consult a physician (Pavone, Banfi, Vaiani & Panconesi, Cephalalgia, September 2007)

PRIMARY HEADACHE - MIGRAINE

- ▶ Subtypes of migraine

- ▶ Episodic Migraine

- ▶ < 72 hours

- ▶ Status Migrainosus

- ▶ > 72 hours

- ▶ Chronic Migraine

- ▶ > 3 months

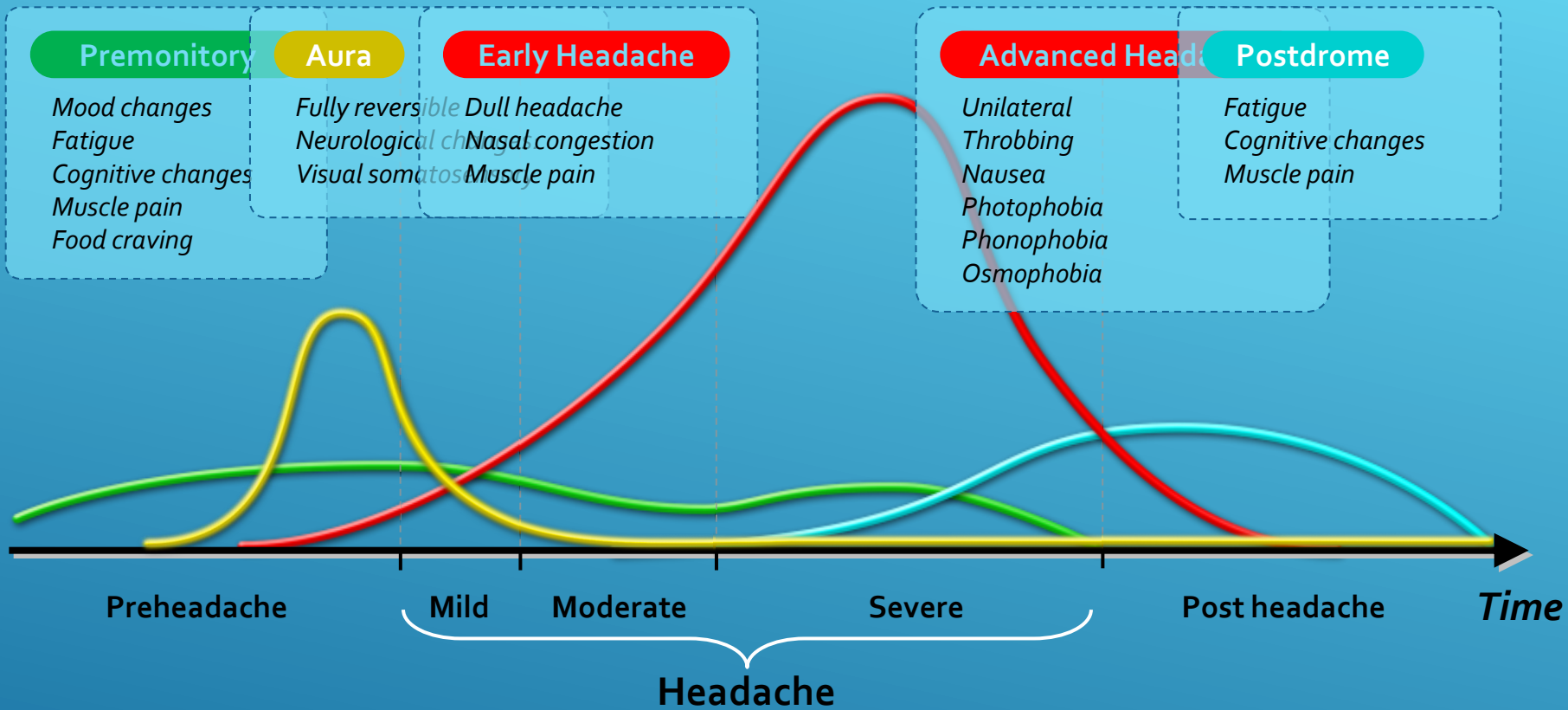
- ▶ > 15 days/months

- ▶ Each > 4 hours

PRIMARY HEADACHE - MIGRAINE

- ▶ At least five attacks
- ▶ Each lasting 4 to 72 hours.
- ▶ The headache should have two or more of the following characteristics:
 - ▶ Unilateral location
 - ▶ Pulsating quality
 - ▶ Moderate to severe pain intensity
 - ▶ Aggravated by or causing avoidance of routine physical activity.
- ▶ The headache should be accompanied by one or more of:
 - ▶ Nausea
 - ▶ Vomiting
 - ▶ Photophobia
 - ▶ Phonophobia.
- ▶ The headache should not be attributable to another disorder.

PRIMARY HEADACHE - MIGRAINE



PRIMARY HEADACHE - MIGRAINE

▶ Medications for acute migraine

- ▶ Paracetamol 1g
- ▶ High dose NSAID's eg. Ibuprofen 400mg, Naproxin 500mg
- ▶ Aspirin 900mg
- ▶ Metoclopramide 10mg
- ▶ Triptan eg. Sumatriptan 6mg s/c or 50mg oral or 10mg intranasal
- ▶ NEVER Co-Codamol

PRIMARY HEADACHE - MIGRAINE

- ▶ Prophylaxis of migraine
 - ▶ Amitriptyline 10mg up to 150mg
 - ▶ Propranolol 80mg up to 240mg
 - ▶ Topiramate 25mg up to 100mg
 - ▶ Candesartan 4mg up to 16mg
 - ▶ Botox injections
 - ▶ **CGRP based therapies**
 - ▶ For menstration related migraine Frovatriptan (2.5 mg twice a day) or Zolmitriptan (2.5 mg twice a day) on the days migraine is expected

PRIMARY HEADACHE - MIGRAINE

- ▶ CGRP medications
 - ▶ Main side effects are local irritation at injection site and constipation.
 - ▶ No known or expected drug-drug interactions
 - ▶ NICE approved in the treatment of chronic and episodic migraine
 - ▶ Initiated under specialist supervision but if effective prescribing from primary care under the shared care structure (amber list)
 - ▶ No monitoring requirements from primary care

PRIMARY HEADACHE - MIGRAINE

- ▶ Emerging therapies for migraine
 - ▶ Magnetic stimulation
 - ▶ Vagal nerve stimulation (gamma core)
 - ▶ Trigeminal nerve stimulation (Cefaly)
 - ▶ Ditans & Gepants



PRIMARY HEADACHE - MIGRAINE

- ▶ In patients with migraine or tension-type headache, regular frequent use of acute treatment can result in exacerbation of the pre-existing primary headache
- ▶ The headache occurs on more than 15 days a month for at least 3 months, affecting between 1-2% of the general population and, up to 20-50% of the chronic headache population
- ▶ All medications used to treat an acute headache can result in medication overuse headaches. Triptans, opioids and combination analgesics are the worst offenders

PRIMARY HEADACHE – MEDICATION OVERUSE HEADACHE

- ▶ Treatment of medication overuse headache
 - ▶ Withdrawal of the offending medication
 - ▶ Studies demonstrate that this is best done as acute stop rather than down titration - likely to feel worse for up to 12 days
 - ▶ There is little evidence from 'bridging' medication but it is common in clinical practice
 - ▶ If comorbid migraine and a high burden of headache it is worth considering commencing a prophylactic medication at onset.
 - ▶ Nearly half of patients will have benefit from medication withdrawal and fewer than one in ten will feel worse than when they started at eight weeks following withdrawal.

PRIMARY HEADACHE – MEDICATION
OVERUSE HEADACHE

- ▶ Tension-Type Headache (TTH) is the most common primary headache disorder with a mean global lifetime prevalence of 42%
- ▶ Chronic tension-type headache affects 0.5 - 4.8 % of the worldwide population
- ▶ Mild to moderate headache which rarely if ever prevents ADL's
 - ▶ Normally not associated with sensory sensitivity and when present these are usually mild
 - ▶ Often the duration of individual episodes is longer than in migraine

PRIMARY HEADACHE – TENSION TYPE

- ▶ Treatment of tension type headache
 - ▶ Short term treatment (PRN or for up to seven days)
 - ▶ Aspirin
 - ▶ Paracetamol
 - ▶ NSAID
 - ▶ Long term management
 - ▶ Amitriptyline/Nortriptyline
 - ▶ Accupuncture
- ▶ Do not offer opioids
 - ▶ Risk of medication overuse headache

PRIMARY HEADACHE – TENSION TYPE

- ▶ Unilateral headache
- ▶ Sever in intensity
- ▶ Pain lasts 15 to 180 min but tents to come in clusters
- ▶ Autonomic symptoms and hyper-motor agitation
- ▶ Affects four men for every woman

PRIMARY HEADACHE - CLUSTER

- ▶ Treatment of acute attacks
 - ▶ Triptan medications
 - ▶ High flow oxygen via NRB mask
 - ▶ NSAID's
- ▶ Prophylactic management
 - ▶ Greater occipital nerve block
 - ▶ Verapamil
 - ▶ Lithium

PRIMARY HEADACHE - CLUSTER

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- ▶ Subarachnoid headache (SAH)
- ▶ Reversible cerebral vasoconstriction syndrome (RCVS)
- ▶ Cerebral venous sinus thrombosis (CVST)
- ▶ Idiopathic Intracranial Hypertension (IIH)
- ▶ Infection
- ▶ Space occupying lesion

SECONDARY HEADACHE

Headache **and**

- ▶ Thunderclap (sudden onset) headache
- ▶ Associated focal neurological deficit
- ▶ Associated systemic features
- ▶ Patients over the age over 50 years without a previous history of headache
- ▶ Patients with risk factors for infection such as immunosuppression or HIV

SECONDARY HEADACHE

- ▶ Temporal arteritis
 - ▶ Pain and tenderness over temple
 - ▶ Vision at risk
 - ▶ Responds well to steroids
- ▶ Acute angle closure glaucoma
 - ▶ Think of this in the elderly patient with acute unilateral headache and visual change
- ▶ CO poisoning
 - ▶ Very common globally but thankfully not so common in UK

SECONDARY HEADACHE – OTHER LESS COMMON CAUSES

- ▶ Headache.org.uk - web version of the BASH guidelines for diagnosis and management of headache
 - ▶ Useful in real time and includes patient information leaflets covering common headache types and medication.

National headache management
system

A decorative graphic consisting of several parallel white lines of varying lengths, slanted diagonally from the bottom right towards the top right, set against a blue background.

- ▶ Enhanced triage of referrals similar to the NARMS model already discussed.
- ▶ Triage directly to imaging for Red Flag headache referrals
- ▶ Provision of written treatment advice where it is felt that this could manage the patients symptoms without the need for a clinical assessment.
- ▶ Provision of a responsive service for those needing face to face assessment
 - ▶ Urgent new patient assessment currently about 12w
 - ▶ Routine new patient assessment currently about 24w

How are we running our headache service?

QUESTIONS?

The image features a blue gradient background that transitions from a lighter shade at the top to a darker shade at the bottom. In the center-left, the word "QUESTIONS?" is written in a white, sans-serif font. On the right side, there are several white, parallel lines that start from the bottom and extend towards the top right corner, creating a sense of movement and depth.