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., JamisonJ., Accident and Emergency Neurology: time for a reappraisal? Health Trends, 1997, 29, 89-91

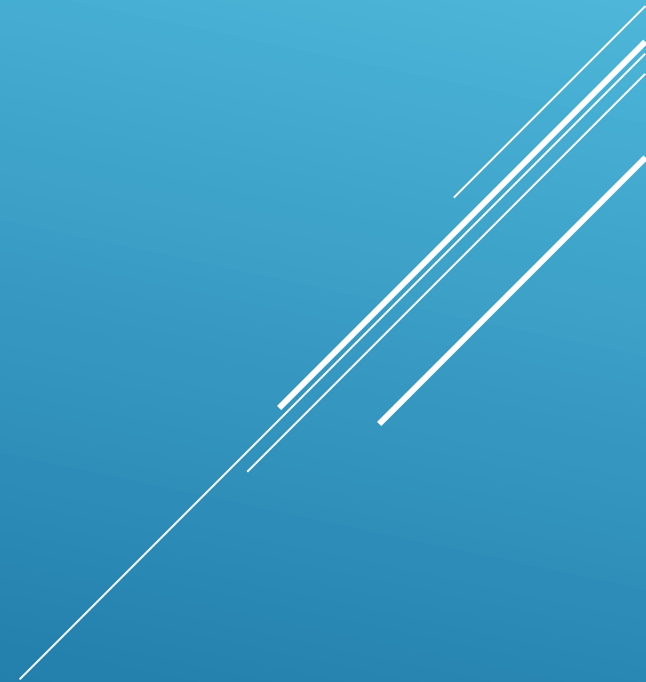
WHY IS HEADACHE IMPORTANT?

- 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?

HOW DOES HEADACHE BREAKDOWN?

- 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%



- 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

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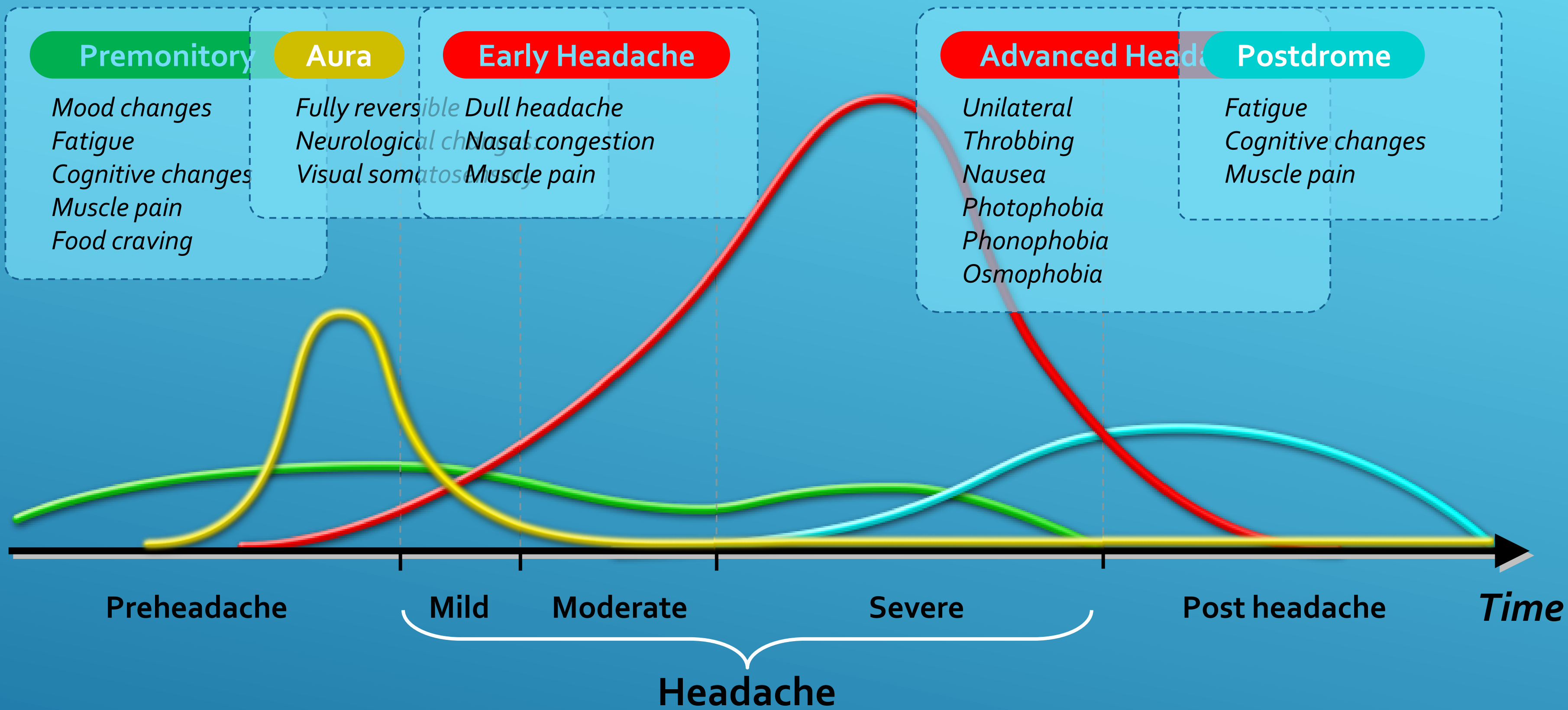
- Subtypes of migraine
  - Episodic Migraine
    - < 72 hours
  - Status Migrainosus
    - > 72 hours
  - Chronic Migraine
    - > 3 months
    - > 15 days/months
    - Each > 4 hours

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

- 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

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

PRIMARY HEADACHE – MEDICATION OVERUSE HEADACHE

- 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

- 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 the started at eight weeks following withdrawl.

PRIMARY HEADACHE – MEDICATION OVERUSE HEADACHE

PRIMARY HEADACHE – TENSION TYPE

- 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

- 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

- Subarachnoid headache (SAH)
- Reversible cerebral vasoconstriction syndrome (RCVS)
- Cerebral venous sinus thrombosis (CVST)
- Idiopathic Intercranial 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 acte 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.

- 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?