All-Wales Management of Primary Headache Disorders in Adults

This is a guideline for the primary care management of the most common headache disorders, aligned with NICE Clinical Guideline CG150

http://qrinfo.icst.org.uk/all-wales-headache-toolkit

See the toolkit

Clinical Pathway

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STEP 1: CONFIRM DIAGNOSIS

Exclude red flags - see Headache Differential Diagnosis Pathway

Is medication overuse causing the headache?
- Triptans, opioids or ergotamines taken on >10 days per month
- Simple analgesics taken for >15 days for >3 months

YES → Withdraw overused medication (abrupt is preferable) before proceeding down the pathway

NO

	Migraine	Tension-type headaches	Cluster headaches
Describe the headache	• Unilateral or bilateral headaches • Pulsing, disabling pain • Moderate or severe pain • Aggrevated by, or causes avoidance of ADLs • 4-72 hours in adults	• Bilateral • Pressing/ tightening pain • Mild or moderate, but not disabling • Not aggrevated by ADL • 30 minutes - continuous	• Unilateral • Sharp, burning, throbbing or tightening pain • Severe or very severe pain • Restlessness or agitation • 15-180 minutes
Associated symptoms?	• Sensitivity to light or sound • Nausea and/or vomiting • Aura, including visual symptoms and/or partial loss of vision • Sensory symptoms such as numbness, pins and needles • Speech disturbance • Neck pain	• None	On side of the headache: • Red and/or watery eye • Nasal congestion • Swollen eyelid • Forehead and facial sweating • Constricted pupil and/or drooping eyelid
Chronic or episodic?	Chronic migraine • At least 15 headache days per month for >3 months	Chronic tension-type headache • At least 15 headache days per month for >3 months	Chronic cluster headache • Attacks occuring >1 year without remission, or remission periods <3 months
Overlap?	Migraine and tension-type headache commonly overlap. If there are any features of migraine, diagnose and manage migraine.		***First presentation:*** *Refer to secondary care for assessment and management plan*

STEP 2: PHARMACOLOGICAL MANAGEMENT

Using acute and preventative treatment options to reduce the intensity and regularity of headaches

Lifestyle advice: Encourage regular balanced meals and fluid intake, avoid excess alcohol, fizzy or caffeinated drinks, regular sleep and daily aerobic exercise, avoid triggers, advise all women of child-bearing age about risks of medications in pregnancy

Acute treatments Taken on onset of an attack Max up to 2-days per week	Combination oral therapy with an oral triptan (unless vomiting, then melt or nasal) and ibuprofen 400-600mg or aspirin 900mg dispersible **OR** Oral triptan (melt or nasal if vomiting) and paracetamol **AND** Consider an anti-emetic, even in the absence of nausea/vomiting **If trial of ≥2 triptans failed**, not tolerated or contraindicated. Consider Rimegepant 75mg once daily. *Refer to LHB formulary and BNF advice.*	Consider aspirin, paracetamol or an NSAID	Subcutaneous or nasal triptan
Preventative treatments Taken daily to reduce the frequency and intensity of headaches	Topiramate (50-100mg daily) or propranolol (80-160mg daily)- discuss benefits/risks of each **OR** Amitriptyline 25-150mg nocte **OR** Candesartan 16mg daily **Failed treatment ≥3 treatments** (for migraine >4 and <15 days per month). Consider Rimegepant 75mg alternate days. *Refer to LHB formulary and BNF advice*	None	As guided by neurology/ headache teams, consider: Verapamil during a bout of cluster headaches (with regular ECG monitoring) Prednisolone
Specialist treatments If no response to at least three preventative therapies	Botox OR AntiCGRP therapy OR GammaCore	None	Various other options may be considered by neurology/ headache teams (e.g. Lithium)

STEP 3: NON-PHARMACOLOGICAL MANAGEMENT

Non-pharma options If no response to at least three preventative therapies	Up to 10 sessions of acupuncture over 5 - 8 weeks (local provision varies)	Up to 10 sessions of acupuncture over 5 - 8 weeks (local provision varies)	Oxygen at least 12 litres/min with non-rebreathing mask and reservoir bag
	Riboflavin supplements (400mg per day)	Consider physiotherapy, regular exercise, CBT and/or relaxation techniques	

Headache diary: Recommend patients use a headache diary to monitor their symptoms, response to medication, and identify any triggers

STEP 4: REVIEW AND REFERRAL

Review after 3-months of starting a new regimen, and 12-months thereafter once the patient is on an established management plan

Who to refer?

Review in primary care
- Assess frequency and intensity of headaches, and compare to previous
- Warn patients about the risk of medication overuse headache (MOH)
- Optimise the management until the patient no longer experiences chronic patterns of the headache disorder
- If headache free for >3 months, consider stepping down
- If no response after 3 months of maximal tolerated dose, consider alternative
- After 3 failed treatment trials, consider referral with headache diary

Refer to headache clinic or neurologist
- The response to treatment is unsatisfactory or treatment options are innappropriate
- There are any red flags or a serious underlying cause of secondary headache is suspected
- There is diagnostic uncertainty or atypical symptoms
- 'Worrying migraine' - new presentation in over 50yrs, changing headache patterns, uncontrolled

Medication Overuse Headache

- Frequently masking the underlying headache disorder is the overuse of acute treatments
- Support the patient to withdraw the overused medication (abrupt is preferable, being mindful of opiate dependance), and start preventative treatment immediately
- Review after 4-8 weeks and proceed down the pathway

Find out more here

Differential diagnosis

- Described as the primary headache disorders, migraine, tension-type headaches and cluster headaches are the most common causes of headache
- Any headache which is not characteristic of these, or an abnormal neurological examination, should be reviewed by Specialist Headache clinic or neurologists.
- ***See Red flag features in All Wales Headache Differential Diagnosis Pathway***

Find out more here

Pharmacological management

- Trial several therapy options to find the most effective for the patient
- Dual therapy, as outlined in the pathway, often potentiates effect (i.e. 1+1=3)
- Explain to the patient the risk of 'medication overuse headache' with the overuse of acute treatments
- Consider quicker onset preparations (e.g. melt, nasal spray or injection)

Find out more here

Non-pharma management

Find out more here

Review and referral

Find out more here