Vale of York
Clinical Commissioning Group

Referral Support Service

Neurology

NE01

Headache Clinic Referrals

MIGRAINES: ***Easily diagnosed with comprehensive history (up to 99%)***

Types of Headache

MIGRAINES WITHOUT AURA:
Lasting 4-72hrs, usually unilateral, pulsating, moderate to severe intensity, aggravated by normal physical activity, associated with nausea, vomiting, photophobia or phonophobia. Behaviour during attack is to seek rest or to be reclusive with impaired function. (5 OR MORE ATTACKS TO CONFIRM DIAGNOSIS).

MIGRAINES WITH AURA:
Progressive, aura last 5-60 minutes prior to headaches:

- *Typical Aura*: homonymous visual disturbance, unilateral parasthesia/numbness, unilateral weakness, dysphasia, a combination of above. (2 OR MORE ATTACKS TO CONFIRM DIAGNOSIS).
- Trigger factors: stress, certain foods, missing meals, too much or too little sleep, bright lights, loud noise, hormonal changes.
- Behaviour during attack is to seek rest or to be reclusive with impaired function.

Tension Type: Episodic or chronic, pressure or tightening and non-pulsating, mild to moderate intensity, bilateral, not worse with activities, generally short lasting-no more than several hours. Often compatible with normal function.

Cluster: Ultra intense pain, unilateral, involving eye and frontal region, several times in 24 hours, can last 15-180 minutes. Associated symptoms: lacrimation, nasal congestion, rhinorrhoea, forehead/facial sweating, ptosis/small pupil, eyelid oedema. Behaviour is often very restless, rocking movements of body, pressure applied to eye/head, inconsolable. Often occurs in bouts for 6-12 weeks, once a year or 2 years, often at same time of each year.

Headache with raised CSF pressure: Initially intermittent and then constant, pain is worse in a morning, and person may be woken by it. Headaches provoked by change in posture, coughing, sneezing, straining or vomiting.

Trigeminal neuralgia: Usually face, unilateral, characterized by lancinating pains limited to the distribution of one or more branches of trigeminal nerve. Pain is paroxysmal, lasting from 2 seconds to 2 minutes Described as intense, sharp, superficial, stabbing, burning or like an electrical shock. Between paroxysms the person is asymptomatic. The person can be free of pain at night.

Responsible GP: Dr Emma Broughton & Dr Shaun O'Connell
Responsible Consultant: Dr Andrew Heald
Responsible Pharmacist: Laura Angus
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Medication overuse headaches:
Associated with **opioids**, **aspirin**, **paracetamol**, **NSAIDS**, **triptans** and **ergotamine**.

- Regular intake of **NSAID** > 15 days a month or **codeine** - containing **Rxs** > 10 days a month.
- Often worse on waking and increase after physical exertion.
- Pre-emptive use of Rx in anticipation of rather than for headache diagnosis based on symptoms and drug use and confirmed only when symptoms improve after Rx withdrawn.

Exclude Red Flag Symptoms and Signs.
Red flags do not always indicate that a headache is necessarily sinister. However, in the correct clinical context, the presence of Red Flag features increases the level of concern. A comprehensive history and full neurological examination is essential.

Red Flag Features:

- Sudden, severe worst-ever headache.
- Rapid build-up over 5 minutes.
- Impaired level of consciousness.
- Headache with pyrexia +/- vomiting.
- Progressive worsening over weeks/months.
- Headache with atypical or very focal aura.
- New aura on hormonal contraception.
- Cognitive changes including change in personality and behaviour.
- Recent head trauma within past 3 months.
- Headache **provoked** by physical activities – cough, sneeze, bend, straining, sports or sexual activity.
- Impaired immunity.
- New onset headache in patient with cancer.

Red Flag Neurological signs on examination:

- Neck stiffness (and pyrexia).
- Non-pulsatile, tender temporal arteries.
- Odd behaviour or cognitive problems.
- Swollen optic discs.
- Focal neurological deficit.

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Management

- First Line: NICE Headache guideline – clear management plans for different classes of headache.
- Useful summary guidance from Sheffield Headache Clinic:

Category	Headache	Medicine Management
A	**Migraine with or without aura**	• **'**Try and try again'- increasing doses of acute migraine therapies. Use prophylaxis treatments (if required) for a minimum of 3-4 months (for each preventative drug). • In cases of suspected primary headaches use a headache diary for a minimum of 8 weeks documenting frequency, duration and severity of headaches, associated symptoms, medications taken to relieve headaches, precipitants and relationship of headaches to menstruation.
A	**Acute treatment Migraine with or without aura**	• 1st line: **NSAID/aspirin/paracetamol** or **sumatriptan** (100mg) 2nd line: 1st line plus Oral/ Non-oral **metoclopramide** or **prochlorperazine.** • 3rd line: Non-oral **paracetamol**, **triptan** (full dose), **metoclopramide**. (Consider MHRA guidance when prescribing metoclopramide).
A	**Prophylaxis Migraine with or without aura**	• 1st line: **beta blockers (propranolol long acting, 80-160 mg per day).** If beta blockers contra-indicated or not tolerated **topiramate (build up slowly to 50mg b.d.).** (Note risk of fetal malformations – need effective contraception. Patient should be fully informed of risk). • 2nd line: **amitriptyline** (10 mg early evening increment up to 50mg over 4 weeks) • 3rd line: **riboflavin (Vitamin B2)** (400mg) may help some migraine sufferers and can be bought from health food shops / OTC in pharmacies • 4th line: **propranolol (if not contraindicated)** and **topiramate** together (see BNF for dosing) • Note NICE say do not use **gabapentin** • NICE suggest preventative treatments are unsuitable consider 10 sessions of acupuncture (not available locally through NHS).
B	**Tension-type headaches**	• Acute treatment: 1st line: **aspirin**, **paracetamol**, **NSAID** • Do not prescribe opioids

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	NB: Cluster headaches - Always refer.	• **Prophylaxis:** Consider up to 10 sessions of acupuncture over 5–8 weeks (not available locally through NHS).
B	Prophylaxis **Tension-type headaches**	• 1st line - **amitriptyline** - titrate up to a dose of 75 mg at night, or the maximum tolerated dose, and review. • For people who do not respond to treatment — discontinue treatment, and manage with psychological treatments alone or refer for further management. • For people who partially respond to treatment — continue titrating up to 150 mg at night or the maximum tolerated dose. • For people who respond well to treatment, maintain the person on the upper dose for 2 months, then decrease the dose by 10 mg to 25 mg each week. • If amitriptyline is poorly tolerated, consider **nortriptyline**. • NICE suggest acupuncture if drug treatments are unsuitable or ineffective however this is not commissioned on the NHS locally.
C	**Medication overuse headaches (MOH)**	• Treatment is to withdraw **ALL ANALGESICS**. Stop abruptly, not gradually, for at least one month • Can lead to withdrawal headache lasting 2-10 days (average 3.5 days) • **NSAIDs**, **Ergots**, **triptans** and **non-opioids** can be stopped abruptly. • Withdrawal of opioids and benzodiazepines usually needs to be gradual to minimize withdrawal symptoms. • Provide close follow-up and support according to the individual's needs. • Consider adjunctive treatment, such as anti-emetics, if the person is not able to manage withdrawal because of withdrawal symptoms. • Ideally wait for 1–2 months following withdrawal of overused medication before considering prophylaxis. • Occasionally, for a person who is unable to otherwise withdraw from the overused medication, prophylactic treatment may be considered in addition to withdrawal. • The choice of prophylactic treatment will depend on the underlying primary headache disorder. See above • Review in 4–8 weeks of the start of withdrawal of overused medication to: ○ Review the diagnosis of MOH.

		○ Assess the need for further management of an underlying primary headache disorder. ○ Overused medications may be re-introduced, with explicit restrictions on their use. ○ Consider prophylaxis for primary headache disorders – see above
D	**Trigeminal Neuralgia**	• 1st line: **Carbamazepine SR** 200mg BD increasing slowly to 1200mg/day. When pain relief has been obtained, attempts should be made to gradually discontinue therapy after 2-3 months of stability / until another attack occurs. If a further attack occurs, reinstate and build up the previously useful medication. NICE says only carbamazepine so if not successful use advice and guidance for further specialist support though our specialist suggests… • 2nd line: **Gabapentin** 300mg OD, increasing as BNF up to 1800mg/day. Higher doses may be required. • 3rd line: **Phenytoin** 100mg OD slowly increasing to 200mg once daily. (Note risk of fetal malformations – need effective contraception. Patient should be fully informed of risk). • 4th line: **Sodium valproate MR** try 200mg daily increasing to up to 1600mg. (Note high risk of fetal malformations – need effective contraception. Patient should be fully informed of risk).

Referral Information for all patients with Headache

NHS
Vale of York
Clinical Commissioning Group

Minimal Information required in the referral letter to the Headache service in York:

A comprehensive clinical history of the headache and associated symptoms including:

- Co-morbidities
- Sleep disturbances
- Mental health issues
- Musculoskeletal problems

A full drug history of all preventative drugs and acute rescue therapies:
What has been tried?

- Combinations?
- Doses?
- Period of treatment?
- Reason for stopping?
- Side-effects?
- Any over the counter drugs?
- Weekly/monthly usage of analgesia and Triptans – excessive?

Neurological examination findings:

- Mental state
- Speech
- Cranial nerves including fundoscopy
- Sensation
- Tone and power testing of limbs
- Coordination and gait

Please document exactly what clinical examination has been performed. Please **do not** write just "CNS = NAD" or "grossly normal".

Include all results of completed investigations. If imaging has taken place please state at which hospital and include a copy of the report.

If a scan is pending please state the type of scan that has been commissioned and where and when the procedure is due to take place.

It is essential that if the patient has seen a Neurologist in the past please include copies all letters and results.

Ensure inappropriate drugs such as **codeine**, **co-codamol**, **tramadol** and **opiates** are discontinued before referral – they have NO role to play in the management of primary headaches.

Ask the patient to keep a simple headache diary to include:

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- Duration of each headache
- Time of day at onset
- Provocations
- Document the frequency of headache
- Response to treatment - indicate dose and combinations

Patient information leaflets/ PDAs

http://www.nhs.uk/conditions/headache/pages/introduction.aspx?nobeta=true

References

- Sheffield Headache Guidance: Dr R Lindert, Consultant Neurologist, General Medicines, Rotherham Foundation Trust, DR S. Nair, Consultant Neurologist, Royal Hallamshire Hospital, Sheffield
- Migraine Trust
- NICE Headache Guideline 2015
- BASH Headache Guidelines