South Tees Hospitals NHS
NHS Foundation Trust

Chronic headache

Primary

- over 90% of chronic headache
- usually migraine - or variant of migraine
- analgesia overuse complicates up to 50% of chronic headache

useful questions:

- how many headache days a month?
- how many severe headache days a month?
- how many painkiller days a month?

if patient is using > 15 analgesia days/month, then analgesia overuse may be the real issue

If patient is using > 8 triptan doses/month, then triptan overuse may be the real issue

Secondary

- rare
- causes:
  - high CSF pressure
    - tumour - rarely presents solely with headache
    - venous thrombosis - usually pregnant or post-partum; on OCP; dehydration
    - IIH - usually overweight young women
  - low CSF pressure
    - very postural - worse upright; better flat
  - inflammatory
    - check ESR/CRP in those at risk

clues to a migrainous headache

- "hideaway" headache - patient wants to lie still
- can wake patient from sleep
- autonomic symptoms - nausea, vomiting, photophobia, phonophobia, dizziness
- aura lasting 10-20 minutes — positive visual phenomena (bright lights, sparkles, zig-zags); tingling hand and face

clues to a cluster headache (or variant)

- agonising - patient wants to roam about
- can wake patient from sleep
- autonomic signs - ptosis, red eye, watering eye, nasal congestion, face feels bruised
- cluster = 1-2 attacks/24 hours
- cluster variant = 6-60 attacks/24 hours

Examination

- In the absence of neurological symptoms, neurological examination is likely to be normal
- All patients should have their fundi visualised - if you cannot see these, get them to see an optician
- Check ESR/CRP in patients in whom temporal arteritis is a possibility

Management

Non-pharmacological

headache diary - see resource for pdf

lifestyle factors

- fatigue
- poor quality sleep
- stress and anxiety
- dietary factors rarely relevant

Pharmacological

analgesia holiday (if relevant)

- stop all analgesia for at least 8 weeks
- expect headache to get worse for up to 2 weeks
- will still get intermittent severe headache but chronic daily headache/ morning headache may start to improve

can use “SOS” analgesia for severe symptoms

SOS

- aspirin 900-1200 mg stat or naproxen 250-500 mg stat - if no contraindication
- anti-emetic (if nausea)
- paracetamol 1g QDS
- triptan preparation - oral, buccal, nasal, injection
- can use up to 8 SOS doses/month

AVOID

- codeine-containing analgesia
- tramadol
- opiates

these painkillers are <u>contraindicated</u> for headache treatment

Prevention

- migraine prophylaxis can take 3 months to work
- patients need to persevere with one treatment, at a decent dose, if at all possible
- options include:
  - amitriptyline/nortriptyline 10-50 mg nocte - often too sedating in younger people
  - topiramate 25 - 100 mg nocte - can cause personality change, weight loss, tingling face and hands
  - propranolol 40-120 mg tds - if not contraindicated for other reasons (asthma)
- numerous other options, usually anti-epileptic drugs, can be initiated after advice from secondary care

Referral criteria

- secondary headache - unless clear surgical aetiology
- cluster headache (and variants) - unless well-controlled
- chronic or severe episodic migraine - unresponsive to above
- please do not refer patients who are taking regular analgesia - unless they have already tried an analgesia holiday

if cluster headache variant:

- consider trial of indomethacin 25-50 mg tads
- if dramatic response, the diagnosis might be “paroxysmal hemicrania”

for cluster headache:

- triptan injection
- high flow oxygen (15l/min via re-breathe bag)
- consider verapamil 40 - 120 mg tds