Wandsworth and Merton: Primary Care Adult Headache Referral and Management Guidance

**Headache**
- “Red Flags”: see overleaf for advice on screening urgent conditions

**Analgesic Overuse?**
- > 15 days/m NSAID / paracetamol
- > 10 days/m opiates / triptans
- Supported withdrawal of analgesia. Identify and treat underlying syndrome

**For all Headache types**
- History, examination and Fundoscopy
- After first Primary Care review if diagnosis is not clear give headache diary and review patient at later date. **
- If still unclear after review consider electronic advice discussion if specific query or referral to Headache Clinic

**Tension Type Headache**
- <8 days/month
  - Simple analgesia (warn about medication overuse)
- 8-15 days/month
  - Consider starting Amitryptiline
  - Reconsider diagnosis
    - (? chronic migraine or secondary headache)
  - Consider electronic advice and guidance or headache clinic referral.
- >15 days/month
  - Start Amitryptiline

**Cluster Headache**
- (new diagnosis or relapse)

**For all Headache types**
- Acute Neurology Clinic / Headache Clinic for urgent review
  - Consider angle-closure glaucoma as differential in elderly
  - Low Frequency
  - High Frequency

**Migraine**
- < 8 days/month
  - Acute treatment (consider prophylaxis, ? menstrual migraine)
  - Reconsider diagnosis
    - (? chronic migraine or secondary headache)
  - TACs: Hemicrania Continua, Paroxysmal Hemicrania, SUNCT

**Chronic Migraine**
- > 15 days/month
  - any headache (migrainous or not)
  - Exclude medication overuse
  - Start Prophylactic Medication
  - Failure to respond after 1 prophylactic at adequate doses after 2 month period → Refer to headache clinic

**Repeat Attenders**
- Referrer to Community Education (CMAC)
  - Failure to respond to 2-3 prophylactics at adequate doses (max tolerated) for at least 2/3 months consider referral to headache clinic

**Cluster Headache (new diagnosis or relapse)**
- Migraine
  - > 15 days/month
  - Any headache (migrainous or not)
  - Exclude medication overuse
  - Start Prophylactic Medication
  - Failure to respond after 1 prophylactic at adequate doses after 2 month period → Refer to headache clinic

**Less common benign diagnoses to consider:**
- Cervicogenic headache (overdiagnosed)
- Primary stabbing headache
- Trigeminal neuralgia
- Primary sex headache
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**MODERATELY URGENT - Headache Amber Flags**

1. >50yr old with genuinely new headache or symptoms suggestive or GCA (e.g. jaw claudication, PMR)
   - Urgent FBC, ESR, CRP
     - Normal ESR, CRP
     - Raised ESR
   - Consider Giant Cell Arteritis and refer to acute medicine
     - Refer urgently before ESR result if visual symptoms

2. New headache with recent head trauma within the last 3 months
   - Consider CT head (direct access local pathway)

3. New headache in 3rd Trimester of Pregnancy or early post-partum
   - Consider electronic advice and urgent referral through acute neurology
     - ? Migraine ? Pre-eclampsia ? Cerebral venous sinus thrombosis

4. New headache in existing cancer or immunocompromised
   - 1. If known to Oncology contact patient’s oncology team directly
     - 2. If not known to oncology consider direct access MRI OR two week rule referral OR if immunocompromised consider acute neurology referral

5. Postural headaches
   - ? Raised ICP (Headache on recumbency, bending forward, Valsalva ± other raised ICP features)
   - ? Low ICP (Headache occurs rapidly on standing, relieved rapidly on lying)
   - ? SOL ? IIH - if typical raised ICP headache refer TWR
     - If unclear consider headache clinic referral
     - If no recent LP or other spinal procedure, consider direct access MRI with contrast OR electronic advice / headache clinic referral

6. Exercise-induced or cough-induced headaches occurring every time with exercise
   - Consider direct access MRI (possible posterior fossa lesions) OR electronic advice OR headache referral

7. New daily persistent headache abrupt onset one day without remission since and without antecedent history of headache
   - Possible secondary headache:
     - consider direct access MRI scan OR headache clinic referral

8. Substantial change in headache phenotype
   - Consider carefully if any red flags. If not, review with headache diary.
     - If no clear diagnosis evident, consider non-urgent Headache Clinic Referral.
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URGENT
HEADACHE RED FLAGS

- New Headache plus Subacute Progressive Focal Neurology
- New Headache Plus Seizures
- New Headache with Personality or Cognitive change not suggestive of Dementia, with no Psychiatric history, and confirmed by witness

Thunderclap Headaches (<5 minutes to maximum severity)

Acute headache with loss or alteration of consciousness

Headache with Systemic symptoms, e.g.
- Malignant hypertension
- Meningism
- Fever

? Giant Cell Arteritis + visual symptoms (+/- ↑ ESR)

Red Eye + Headache (especially elderly)

Red Eye + Headache (esp. elderly)

Consider Angle Closure Glaucoma
(ΔΔ Cluster Headache or related disorder)

Emergency referral
(Local Acute Medicine)

Emergency referral
(Eye clinic)

Two Week Rule Referral
If high level of concern discuss with acute neurology service

- Headache with raised ICP features AND severe vomiting, drowsiness ± papilloedema or visual loss

Emergency referral
(Local Acute Medicine)