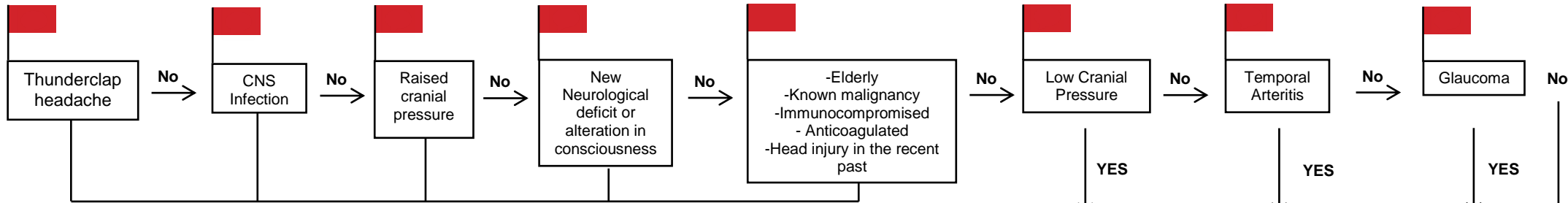


Acute (Secondary Care) Headache pathway for adults

Hover over red flags and other highlighted links for more information

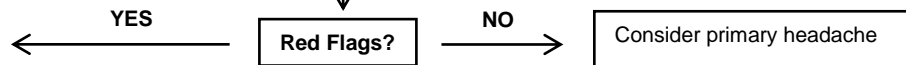
Patient presents with severe headache
Take full history and carry out a full neurological examination
Do not omit visual acuity and fields, optic fundi, meningism and gait. Check temperature, skin (rash), BP and gait.

Are any of the following red flags present?



CT Brain Scan – consider with contrast
Discuss scan report with radiologist & senior colleague
If indicated, proceed to do a lumbar puncture if safe to do so
If indicated discuss with the **Walton Centre on-call Neurosurgical or Neurology Registrar**

If no abnormalities on investigations, reassess patient again



Episodic Migrane with and without aura

Avoid starting regular analgesia. Pain Control (paracetamol / NSAID +/- triptan +/- prokinetic anti-emetic) should be used sparingly for 1-2 days only. Ensure adequate hydration.
Patient should be supplied with Walton migraine leaflet and advised to consult GP about options on Walton primary care headache pathway.

Chronic Migrane

Discuss diagnosis and give **INFROMATON LEAFLET**
Stop use of regular analgesics- withdraw opiates slowly Advise patients to stop all caffeine intake
Advise patients to limit acute attack analgesic medication use to a maximum of 2 does a week and only for severe attacks. e.g. paracetamol 1gm or ASPIRIN 600mg or NAPROXEN 500mg or IBUPROFEN 400mg for severe headaches but not more than twice a week. DO NOT PRESCRIBE CODEINE/MORPHINE/TRAMADOL and other opiates
Patient should be supplied with Walton Migraine leaflet and advised to consult GP about options on Walton primary care headache pathway regarding preventative treatments.

Medication overuse headache

Discuss diagnosis and give **INFORMATION LEAFLET**
Stop use of regular analgesics - withdraw opiates slowly Advise patients to stop all caffeine intake
Advise patients to limit acute attack analgesic medication use to a maximum of 2 doses a week and only for severe attacks e.g. paracetamol 1gm or ASPIRIN 600mg or NAPROXEN 500mg or IBUPROFEN 400mg for severe headaches , but not more than twice a week, DO NOT PRESCRIBE CODEINE/MORPHINE/TRAMADOL and other opiates
Warn patients that headaches will worsen for the first 2-3 weeks and that headaches will resolve only over a few months
Patient should be supplied with Walton migraine leaflet and advised to consult GPO about options on Walton primary care headache pathway regarding preventative treatments

Chronic tension headache

Simple analgesics like paracetamol or ibuprofen (max 2 does per week to avoid medication overuse headache)
Discuss diagnosis and give **INFORMATION LEAFLET**
Patient should be advised to consult GP about options on Walton primary care headache pathway regarding treatments

Cluster Headache

(a) Administer subcutaneous SAMATRIPTAN INJECTION (refer hospital formulary) to terminate an acute attack
(b) 12-15 Litres/min high flow oxygen through a non rebreathable, tight fitting mask (caution in COPD) to terminate an acute attack
If having regular attacks, commence **PREDNISOLONE** 60mg daily for 3 days; reducing by 10mg every 3 days until stopped; maximum duration =18 days
Verapamil 40mg tds increasing over a week if tolerated to 80mg tds (unlicensed indication but well established in neurology)
Consider PPI prophylaxis
Supply patient with sumatriptan 6mg sc injections (maximum 2 per day)
Discuss diagnosis and give **INFORMATION LEAFLET**
Refer for **NEUROLOGY OUTPATIENT APPOINTMENT**

Trigeminal Neuralgia

Ask for history of zoster of the affected area (post herpetic neuralgia)
IV fluids if oral intake affected by symptoms
Commence **CARBAMAZEPINE** or **GABAPENTIN** – (Refer hospital formulary)
Discuss diagnosis and give **INFORMATION LEAFLET**
Refer for **NEUROLOGY OUTPATIENT APPOINTMENT**