Acute (Secondary Care) Headache pathway for adults

The Walton Centre NHS Foundation Trust

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?

Thunderclap headache → No → CNS Infection → No → Raised cranial pressure → No → New Neurological deficit or alteration in consciousness → No → -Elderly -Known malignancy -Immunocompromised - Anticoagulated -Head injury in the recent past → No → Low Cranial Pressure → No → Temporal Arteritis → No → Glaucoma → No

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

Discuss with senior colleague and Walton Centre Neurosurgical or Neurology Registrar / Visiting Neurology consultant

If no abnormalities on investigations, reassess patient again

Red Flags?

YES

NO

Consider primary headache

YES

Lie Flat

Hydrate with IV fluids over 48-72 hours, IV antiemetics and NSAID.

If no history of a spinal puncture, arrange an MRI of the brain and spine with contrast to look for features of low cranial pressure.

If no improvement after 48-72 hour, liaise with Walton centre neurology reg on call for advice.

YES

Urgent ESR and CRP then commence steroid therapy immediately – prednisolone 1mg/kg/day (Maximum 100mg)
Aspirin 75mg daily
PPI prophylaxis

Refer to appropriate department to urgent temporal artery biopsy

Refer urgently to ophthalmology if any visual symptoms

YES

Emergency opthamology referral

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/MORPHNE/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 diagnonsis 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