



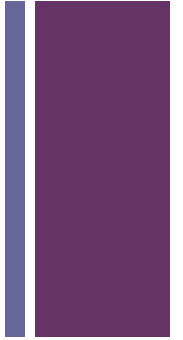
Practical Headache-ology

Dr. Mark Fish

Consultant Neurologist



Introduction



- Headaches not to miss
- Common Headache syndromes
- Avoidable headaches
- Management



Red Flags



- Sudden onset
- Focal symptoms and signs
- Fever, meningism
- Confusion or seizures
- 'Pressure' features – worse with cough / strain / posture change / exertion
- Over 60 with systemic malaise, temporal tenderness
- Red painful eye, vomiting, fixed pupil, 'halos'



Don't Miss:

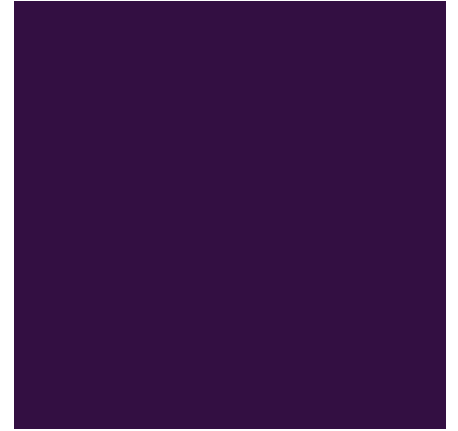
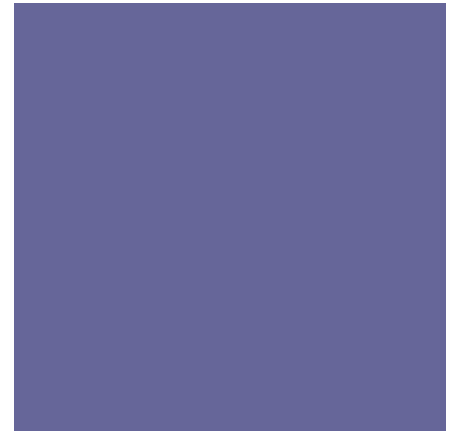


- Severe, sudden onset - ***consider SAH, venous thrombosis***
- Focal symptoms and signs – ***consider SOL, seizure, venous thrombosis***
- Fever, meningism - ***meningitis***
- Confusion or seizures - ***meningoencephalitis***
- 'Pressure' features – worse with cough / strain / posture change / exertion – ***consider SOL, idiopathic intracranial hypertension, obstruction to CSF flow***
- Over 60 with systemic malaise, temporal tenderness – ***consider temporal arteritis***
- Red painful eye, vomiting, fixed pupil, 'halos' – ***consider glaucoma***

+ When to scan

- New focal symptoms or signs
- Features of raised ICP – morning headache, worse with valsalva
- Concern re missed aneurysm
- Associated features such as seizures or confusion
- *Consider* for anxiolysis

- NB Chronic daily headache is almost never due to a tumour.





Common Headache Syndromes





Common Headache Syndromes





Common Headache Syndromes



*'Headache without
features'*



Common Headache Syndromes



Tension Headache



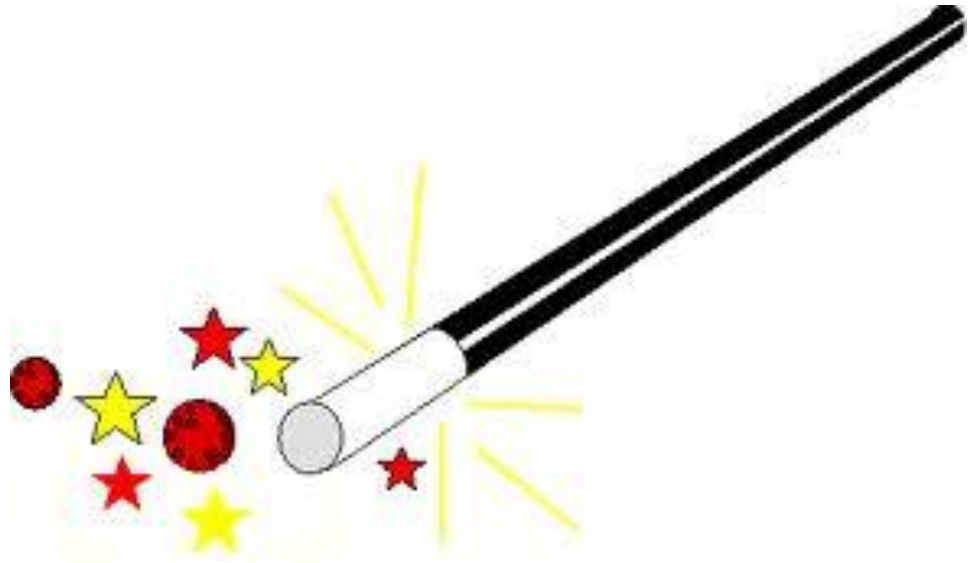
Common Headache Syndromes

Emanates from outside the skull...



+ Muscle contraction - management

- Address musculoskeletal issues
- Physical exercise
- Stress management
- Amitriptyline





Headaches with features:





1) Trigeminal autonomic cephalgia (cluster & variants)



Spot the error

1) Trigeminal autonomic cephalgia (cluster & variants)



Spot the error

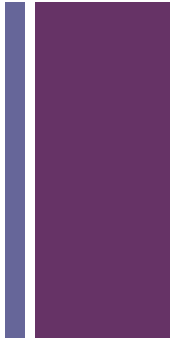


Cluster Variant / trigeminal autonomic cephalgia



- Trigeminal distribution pain
- Ipsilateral autonomic features
- Generally severe

+ Cluster management



- Acute – high flow oxygen via non-rebreathing mask
- S/C sumatriptan 6mg up to 2x /day
- Intra-nasal lidocaine 20-60mg

- Preventative – Short course of prednisolone – 60mg for 1/52 – tail off over 3 weeks
- Pizotifen – increase in 500mcg steps to 1.5mg
- Verapamil with ecgs at dose increments (start 80mg bd, 80mg increments at 2 weekly intervals, up to 320mg tds)

† Short lived, frequent paroxysms (SUNCT, ISH, Paroxysmal Hemicrania, (TN))

- More likely to respond to gabapentin, carbamazepine, lamotrigine
- Consider trial of indomethacin (start 25mg tds 10 days, then try 50mg tds, 75mg tds if required. Try for 10 days.)

+ Indomethacin responsive headaches

- 'Jabs and Jolts', 'needle in the eye'
- Benign exertional headache , Benign coital headache – can try indomethacin 25 –50mg 2 hours prior to exertions
- Primary cough headache
- Hemicrania continua (continuous, unilateral with autonomic features)
- Paroxysmal hemicrania (short - minutes high freq attacks, worse with movement)
- Hypnic Headache (age >50 periodic, from sleep, lasts minutes)
- ***Most of the above will require imaging at outset***

+ Headache with features – 2)

- Throbbing
- Asymmetric
- Nauseated / vomiting
- Photo / Phono phobic



+ Headache with features – 2) Migraine

- Throbbing
- Asymmetric
- Nauseated / vomiting
- Photo / Phono phobic
- +/- focal symptoms or deficit (with / without aura)



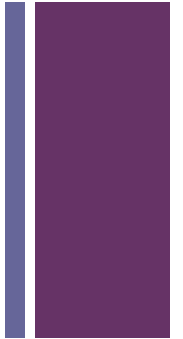


+ Migraine



+ Migraine features

- Stereotyped
- Hormonally influenced
- Duration minutes - days
- +/- Focal Deficit (not always visual)
- Evolution minutes – hours (if seconds consider focal seizure)
- **New onset focal deficit always needs investigating**
- ‘Transforms’ over years
- Symptoms can ‘escape’
- Can rebound, including due to triptans

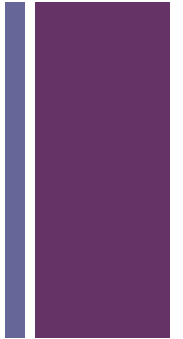


+ Migraine versus Cluster

- Gradual onset, prolonged tailing off
- Typically hours
- Any deficit - spreads
- +/- autonomic features
- Cyclical
- *Curls up in the dark*
- Sudden onset and cessation
- Typically Minutes
- Trigeminal territory
- Prominent autonomic activation
- Periodicity (daily, annually)
- *Paces around, head butts wall*

+ Migraine management

- Triggers / Lifestyle. Consider stopping hormonal contraception.
 - Acute – try high dose aspirin (300-900mg) +/- domperidone before triptan
 - Preventative options
 - Amitriptyline
 - Sodium Valproate
 - Topiramate
 - Beta blocker
 - Pizotifen
 - Gabapentin
- Fully explore each option – escalate as tolerated and persist



+ Daily Headache management

- Consider temporal arteritis, hemicrania continua, transformed migraine, idiopathic intracranial hypertension
- Lifestyle / Stress / Exercise
- Reduce and stop regular and 'just in case analgesia'
- Amitriptyline is useful preventative. Escalate as tolerated. Need to persist for 4-6/52
- If there are persistent migrainous features, other migraine prophylaxis may be justified



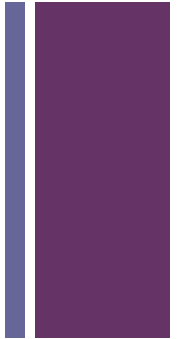
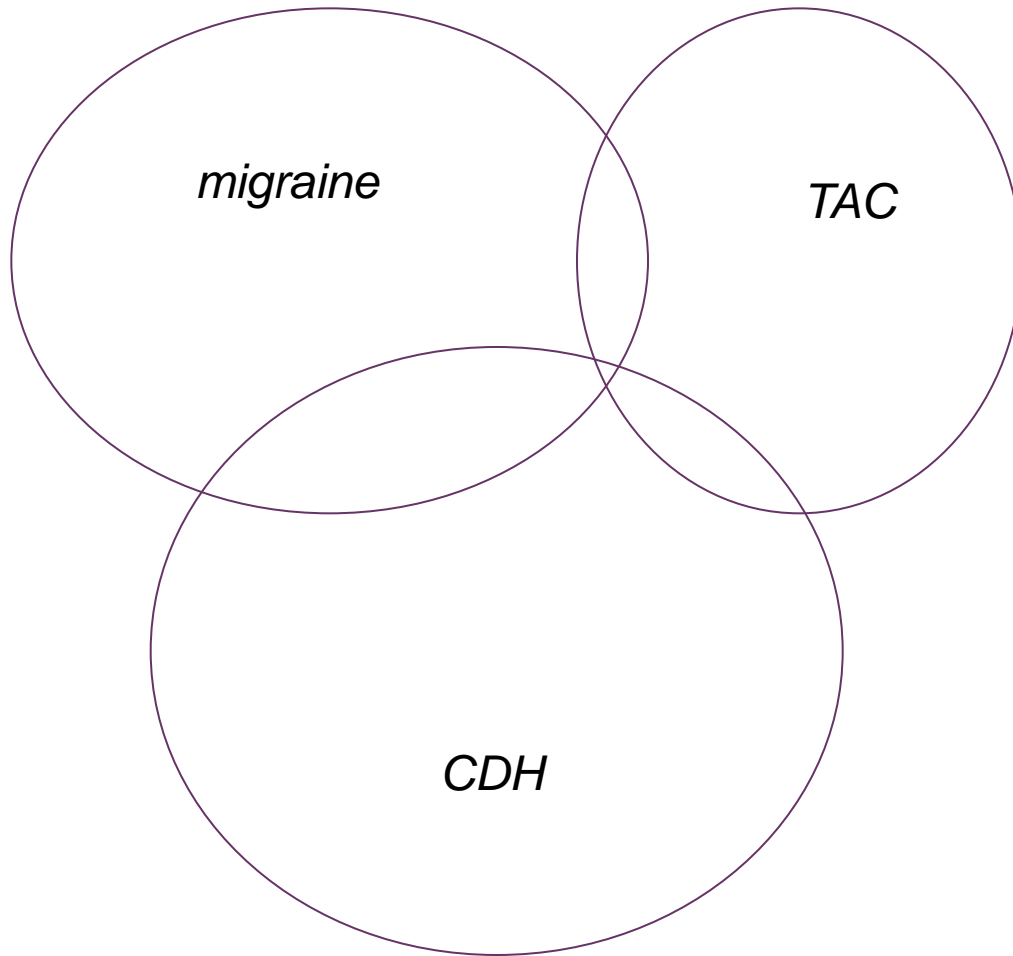
Avoidable headache - Rebound



- Any analgesia can do this
- Tramadol or codeine > triptans > simple analgesia
- Don't prescribe codydramol / tramadol for headache (often started in hospital)
- Monitor analgesia repeat prescriptions
- Prevention may be easier than cure – warn all headache patients of the risk

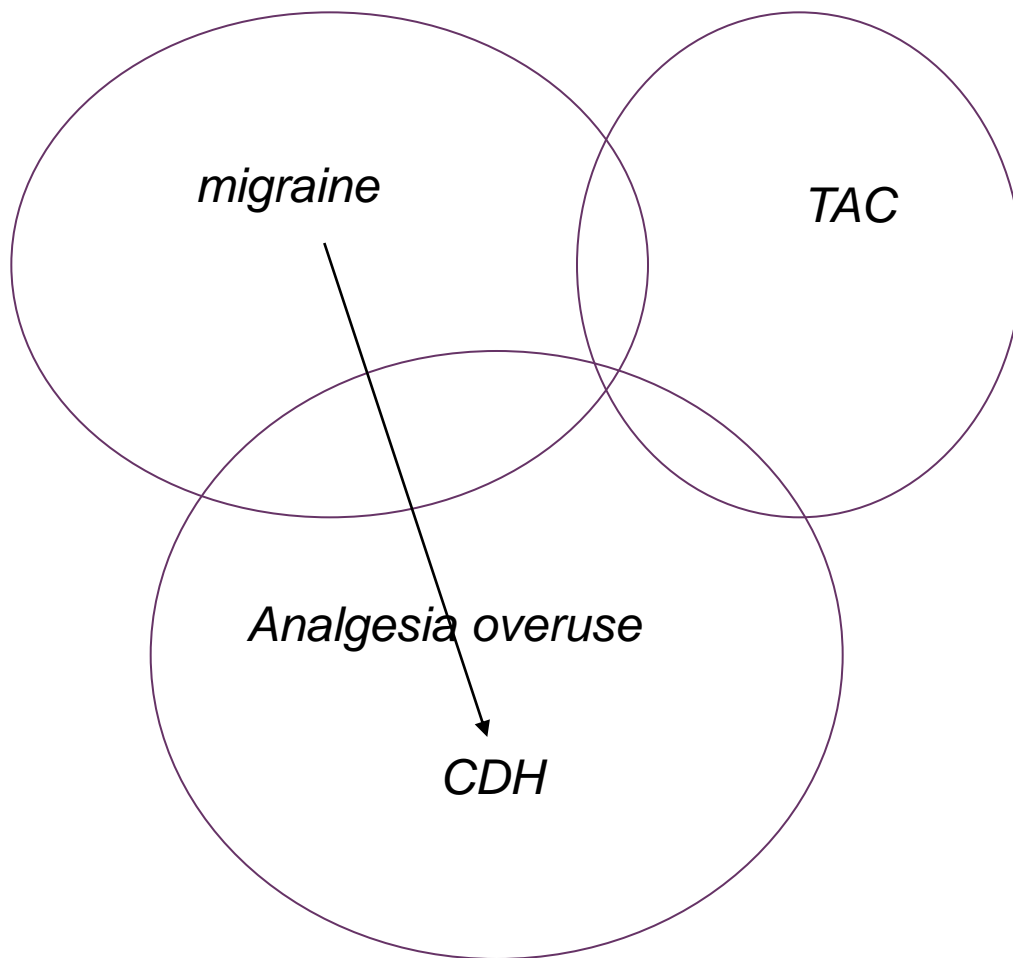


Make a best fit diagnosis





Avoid causing rebound





Treat the most treatable

