Headaches in Adults

See also Headaches in Children.

Red flags

- Sudden onset occipital headache
- Meningism or fever
- Abnormal neurology or mental state
- Papilloedema or other features of raised intracranial pressure

Background

About headaches in adults

Assessment

1. Take a detailed history. Look for concerning features of secondary causes of headache.
2. Assess for features of primary headaches, considering that a patient may have 2 or more coexisting types:
    - Tension-type headache
    - Migraine
    - Medication overuse headache
    - Cluster headache
3. Recommend a headache diary to assess self-medication and aid diagnosis.
4. Consider sleep apnoea if patient regularly wakes with a headache.
5. Examination:
    - Vital signs – assess blood pressure, pulse, respiration rate, temperature and oxygen saturation levels.
    - BMI – if raised and features of raised intracranial pressure (ICP), consider idiopathic intracranial hypertension (IIH).
    - General appearance and mental state – look for signs of serious causes of headache such as skin rash, changes in level of consciousness or confusion.

- Extracranial structures – assess the carotid arteries, temporal arteries (to check if they are tender or pulseless), sinuses, and temporomandibular joints.
- The neck – look for signs of meningeal irritation, tenderness of cervical paraspinal muscles, limitation in range of movement and crepitation.
- Perform a brief neurological examination.

6. Consider investigations:
    - CRP/ESR if patient older than 50 years without past headaches
    - Optician assessment
    - CT head – imaging is not usually required unless there are features suggesting mass lesion or metastatic disease

Management

1. If in telephone consultation with a patient experiencing any concerning features of acute causes of headache, advise them to phone 999 for an ambulance.
2. Request emergency assessment in accident and emergency (A&E) if:
    - airway, breathing, or circulation are compromised.
    - head injury in the last month and subdural haemorrhage is suspected.
3. Otherwise, manage according to presentation:
    - Request acute general medicine assessment if:
        - first-ever sudden onset (thunderclap) severe headache or significant change in character or severity of usual headache.
        - first-ever headache with focal neurological signs, confusion, or drowsiness.
        - papilloedema and other features of raised intracranial pressure, e.g. headache worse when lying down, vomiting, or coughing.
        - headache with systemic symptoms of illness, e.g. meningism, rash, or fever.
        - limb or facial weakness, or any speech difficulties.
    - Request acute ophthalmology assessment if.
        - eye symptoms, e.g. monocular pain, red eye, visual disturbance, nausea, and acute angle closure glaucoma is suspected.
        - symptoms suggestive of idiopathic intracranial hypertension and visual loss.
4. If any suspected serious secondary cause, depending on suspected cause and clinical assessment, either:
    - refer the patient for an urgent CT scan (via ICE clinical system) or seek radiology advice.
    - request emergency assessment via ambulatory care.

5. For all other primary headaches, manage in general practice:
    - Provide reassurance and education
    - Explain and discuss diagnosis
    - Address any anxiety about serious pathology
    - Avoid treatment with opioids, including codeine, due to the risk of medication overuse headaches.
    - Consider suggesting attendance at the local Headache forum, for details of the next forum contact the neurology secretaries.
6. Manage a patient with a specific primary headache according to type:
    - Tension-type headache management
    - Migraine management
    - Medication overuse headache management
    - Cluster headache management
    - Idiopathic intracranial hypertension management

Request

- Request emergency assessment in accident and emergency (A&E) if:
    - airway, breathing, or circulation are compromised.
    - head injury in the last month and subdural haemorrhage is suspected.
- Request acute general medicine assessment if:
    - first-ever sudden onset (thunderclap) severe headache or significant change in character or severity of usual headache.
    - first-ever headache with focal neurological signs, confusion, or drowsiness.
    - papilloedema and other features of raised intracranial pressure
    - headache with systemic symptoms of illness
    - speech, limb, or facial weakness.
    - head injury in the last month.
- Request acute ophthalmology assessment if symptoms suggestive of.
    - acute angle closure glaucoma.
    - idiopathic intracranial hypertension and visual loss.
- If any suspected serious secondary cause, depending on suspected cause, consider request emergency assessment via ambulatory care.

- If cluster headache not controlled by treatment, request urgent routine neurology assessment to consider greater occipital nerve block or prophylactic treatment.
- Request routine neurology assessment if:
    - migraine prophylaxis is unsuccessful after 2 or 3 agents at maximum tolerated doses.
    - chronic migraine and 3 medications have proven ineffective or poorly-tolerated, for consideration of Botox.
    - idiopathic intracranial hypertension requiring confirmation of diagnosis.
- If considering migraine medication and not confident in prescribing, request routine neurology assessment or seek neurology advice.
- Seek neurology advice if:
    - medication overuse headache continues after all medications have been stopped for 8 to 12 weeks.
    - prophylactic treatment for migraine is needed during pregnancy.
- If chronic persistent headaches, consider requesting chronic pain specialised assessment.

CHILDRENS PATHWAY IN PROCESS OF BEING WRITTEN FOR NORTH CUMBRIA SPECIFICALLY.

Hypertension

See also Hypertension in Pregnancy and Postpartum.

Red flags

- Blood pressure 180/120 mmHg or higher, with headaches, papilloedema, or proteinuria

Assessment

1. History:
    - Consider symptoms of high blood pressure
    - Ask about contributing factors, including:
        - salt and alcohol intake.
        - lack of exercise.
        - illicit substance abuse including anabolic steroids.
        - exercise.
        - family history of hypertension.

2. Take blood pressure measurements.
3. Assess further:
    - If blood pressure (BP) is higher than 140/90 mmHg but lower than 180/120 mmHg, consider ambulatory blood pressure monitoring (ABPM) (preferred) or, if ABPM is not tolerated or available, home monitoring to confirm hypertension.
    - If BP higher than 140/90 mmHg then assess target organ damage.
4. Confirm and grade hypertension after ambulatory BP or home monitor.
5. If hypertension is confirmed:
    - Check for common exacerbating factors of hypertension
    - Consider secondary causes
    - If severely elevated blood pressure, e.g. systolic 180 mmHg or higher or diastolic 120 mmHg or higher, look for evidence of malignant hypertension
    - Calculate cardiovascular risk
    - Perform a hypertension examination
    - Arrange investigations

Management

1. If suspected malignant hypertension or phaeochromocytoma, request acute general medicine assessment.
2. If the patient has chronic kidney disease, follow the Chronic Kidney Disease (CKD) in Adults pathway.
3. Manage hypertension after ABPM or home monitoring according to severity:
    - If the patient has stage 1 hypertension, is younger than 80 years, and has any concerning features, determine target blood pressure and treat with oral anti-hypertensives.
    - If the patient has stage 1 hypertension and is younger than 60 years, consider treatment of hypertension in addition to lifestyle advice even if QRISK is less than 10%.
    - If stage 2 hypertension, treat with oral anti-hypertensives.
    - If severe hypertension without features of malignant hypertension, manage with oral anti-hypertensives in the community and review within 7 days.
4. Request non-acute general medicine assessment in the Hypertension Clinic if:
    - hypertension is not controlled despite treatment with 3 concurrent medications at adequate doses, or unacceptable side-effects.
    - the patient is younger than 40 years.
    - suspected secondary cause of hypertension.
    - there is left ventricular hypertrophy on ECG – these patients require an echocardiogram.

5. Provide advice on:
    - lifestyle interventions.
    - side-effects.
6. Consider treatment with statins if:
    - QRISK is 10% or higher, or
    - the patient is younger than 55 years. QRISK is underestimated in these patients. Make an individual assessment based on family history and other risk factors, taking patient choice into account.

Request

- If suspected malignant hypertension or phaeochromocytoma, request acute general medicine assessment.
- Request non-acute general medicine assessment in the Hypertension Clinic if:
    - hypertension is not controlled despite treatment with 3 concurrent medications at adequate doses, or unacceptable side-effects.
    - the patient is younger than 40 years with hypertension.
    - suspected secondary cause of hypertension.
    - there is left ventricular hypertrophy on ECG – these patients require an echocardiogram.
- If considering treatment in a patient younger than 60 years with stage 1 hypertension and unsure, seek non-acute general medicine advice.