Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY COUNTY COUNCIL

NHS

Surrey Heartlands ICS

Primary Care Adult Headache Referral and Management Guidance – for over 18's

February 2023

Headache Pathway

Referral forms are available on EMIS and SystemOne

HEADACHE

For all patients, offer lifestyle advice, trigger factors, review if on COC, headache diary, warn of medication overuse.

For headache diary, consider apps such as migraine buddy app.

** Other diagnosis to consider:
- Cervicogenic headache / OSAS
- TMJ
- Primary stabbing headache
- Trigeminal neuralgia (does require non urgent imaging)
- Primary sex headache
- TACs: Hemicrania Continua, Paroxysmal Hemicrania, SUNCT

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 (BP) and consider optician review for 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.

'Amber and Red Flags' – See page 2 and 3 for advice on screening for potential secondary causes of headache.

Tension Type Headache

< 8 days /month

Simple analgesia (warn about medication overuse)

8-15 days /month

Consider starting Amitryptiline

> 15 /month

Start Amitryptiline

Reconsider diagnosis (chronic migraine or secondary headache)

Consider electronic advice and guidance or headache clinic referral

Cluster headache (new diagnosis or relapse

Acute Neurology

Clinic / Headache Clinic for urgent review/ Advice

Consider angle-closure glaucoma as differential in elderly

Migraine

Low frequency

< 8 days /month

Acute treatment (consider prophylaxis, menstrual migraine)

High frequency

8-15 days /month

Limit analgesia
Prophylactic Rx, any of:

Propranolol
Topiramate
Amitriptyline
Candesartan
Failure to respond to 2-3 prophylactics at adequate dose least 2-3 months, consider Clinic.

Chronic Migraine

> 15 /month
Any headache (migrainous or not)

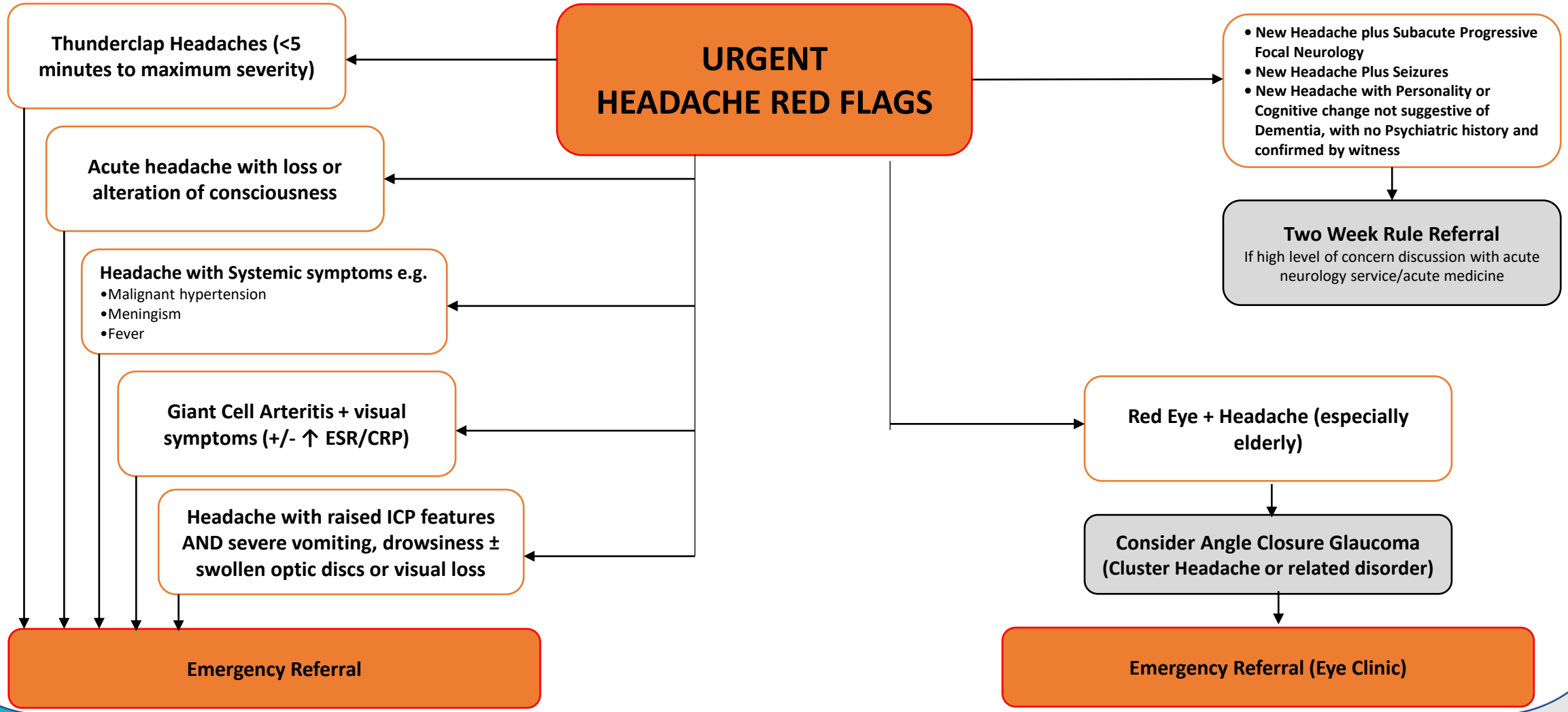
Exclude medication overuse.
Start prophylactic medication.
Failure to respond after 1 prophyatic at adequate doses after 2 month period, refer to Headache Clinic .

Screening Advice

HEADACHE AMBER FLAGS – pause and consider secondary causes.
For all amber pathway patients consider discussion with neurologist via advice and guidance/mobile/consultant connect

>50 yr old with genuine new headache or symptoms suggestive of GCA (e.g. jaw claudication, PMR)	Urgent FBC, ESR and CRP if possible	Normal ESR/ CRP → Re-evaluate history with headache diary (common benign syndrome). If genuinely new headache consider headache clinic referral
		Raised ESR/ CRP (>50) → Consider Giant Cell Arteritis and refer to acute medicine/rheumatology. Refer urgently before ESR/CRP result if visual symptoms
New headache with recent head trauma within the last 3 mths if > 45yrs and/or anticoagulation	Consider CT head (though local pathway direct to test)	
New headache in 3rd Trimester of pregnancy or early post-partum.	Consider electronic advice and/or urgent referral through acute obstetrics /neurology (Migraine/Pre-eclampsia/Cerebral venous sinus thrombosis).	
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 two week rule referral **OR** if immuno-compromised consider acute neurology referral or direct to test via neurology	
Postural headaches	**Raised ICP** (Headache on recumbency, bending forward, swollen optic discs, Valsalva ± other raised ICP features	**SOL/IIH - if typical raised ICP headache refer TWR If unclear consider headache clinic referral**
	Low ICP (Headache occurs rapidly on standing/relieved rapidly on lying)	**If no recent LP or other spinal procedure, consider electronic advice / headache clinic referral**
Exercise induced or cough induced headaches – occurring every time with exercise.	Consider electronic advice or Headache Clinic Referral.	
New daily persistent h/ache abrupt onset one day without remission since & without antecedent history of h/ache	Possible secondary headache: consider imaging via A and G/TWR or Headache Clinic Referral.	
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.	

Red Flags


URGENT HEADACHE RED FLAGS
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/CRP)
Headache with raised ICP features AND severe vomiting, drowsiness ± swollen optic discs or visual loss
Emergency Referral
• 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
Two Week Rule Referral
If high level of concern discussion with acute neurology service/acute medicine
Red Eye + Headache (especially elderly)
Consider Angle Closure Glaucoma (Cluster Headache or related disorder)
Emergency Referral (Eye Clinic)

Monthly Headache Diary

Name: DOB:

Month: **Year:**

Date	Day	Time	Severity (1-10)	Duration (mins/hrs)	Nausea (N)/ Vomiting (V)	Painkillers (Name/Dose)	Notes (triggers, period, changes in preventatives, side effects etc.)
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