Acute Headache Primary Care Urgent Care Pathway

City and Hackney Clinical Commissioning Group

Clinical Presentation

History – temporal profile, location, character, history of trauma, exacerbating and relieving factors, previous episodes, medication use, health between attacks, family history of similar headaches

Examination –

General: temp, BP, HR, RR, GCS, level of confusion, sinuses, scalp arteries, cervical paraspinal muscles, neck posture, range of movement, muscle tone and tenderness, neck flexion vs lateral rotation and and kernig's sign (*meningeal irritation*)

Neurological: neurological examination including fundoscopy

Refer patients **immediately** to hospital as an emergency if presenting with:

- Thunderclap headache – extreme intensity headache, reaches maximal intensity in a very short time (up to 5 minutes) and lasts longer than 1hr
- Fever, systemic illness, photophobia, neck stiffness, focal signs, reduced consciousness.
- Headache with focal neurological signs or seizures
- Headache associated with severe unilateral eye pain, red eye, fixed and dilated pupil, hazy cornea, or diminished vision
- Headache associated with nausea and impaired concentration in a patient exposed to potential carbon monoxide source

Refer patient to either to Homerton Hospital A&E, acute medical registrar or neurology registrar.

If suspect acute stroke refer to Royal London Hyper Acute Stroke Team

If suspect acute glaucoma refer to Moorfields Eye Hospital

Refer patients for **urgent** investigation if:

Headache associated with other 'red flag' symptoms:

- New onset daily headache in high risk group
  - Over 50s
  - Cancer or history of cancer
  - Immuno-compromised
- Features suggestive of low/high CSF pressure
  - Postural headache
  - Persistent or recurrent morning headaches with nausea
  - Precipitated by cough, laughing, straining, sexual intercourse, physical exertion
- Cognitive or personality change
- Associated with tenderness over temporal artery, jaw claudication, systemic malaise
- Progressive headache, worsening over weeks or longer
- New headache where a diagnostic pattern has not emerged after 8 weeks from presentation

Discuss patient with neurology SpR or neurology email advice service: huh-tr.NeurologyHomerton@nhs.net
Refer patients as per discussion with neurology.

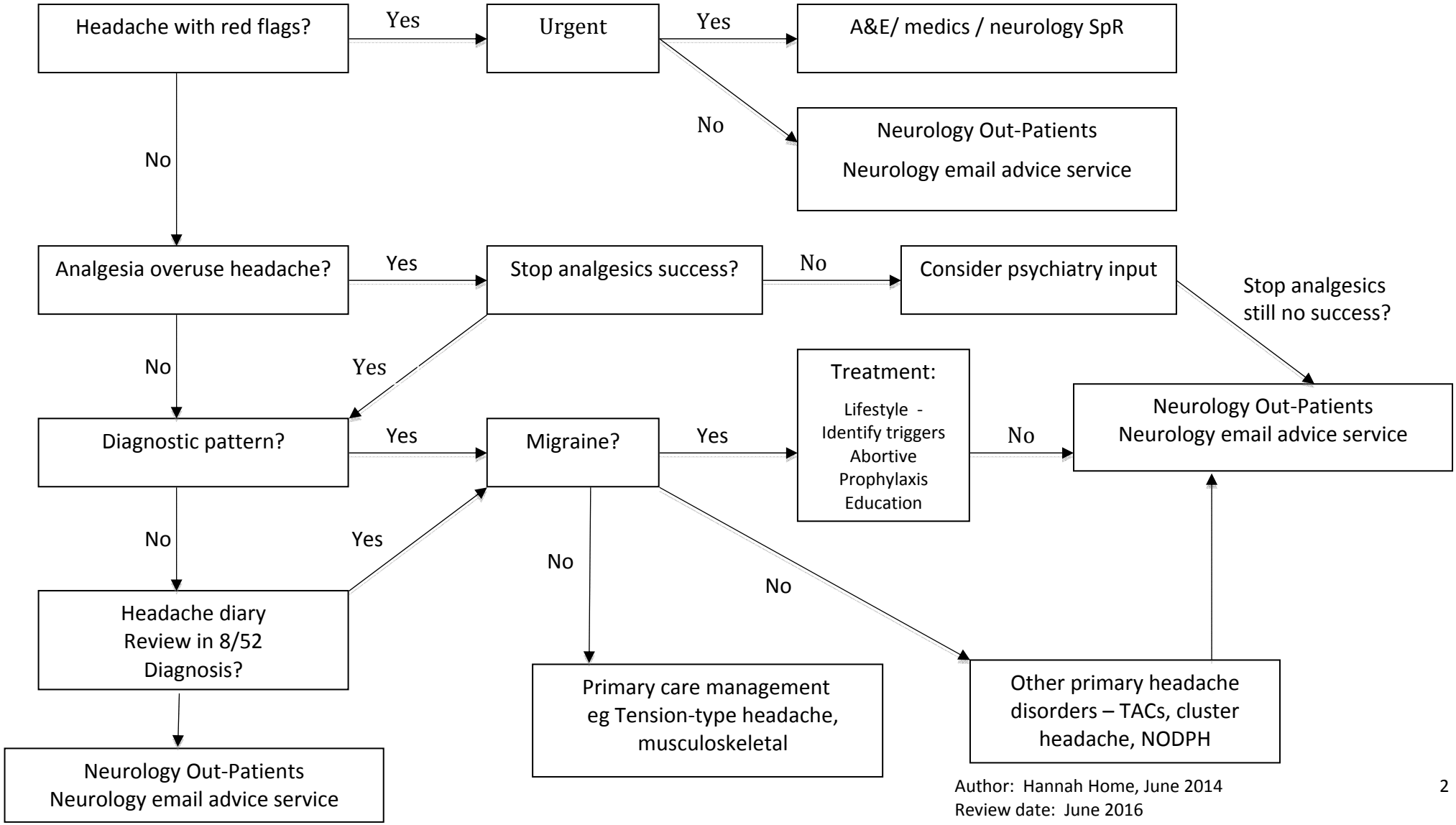
Primary Care Management

- If no suspicious features treat as primary headache syndrome. If no initial diagnostic pattern consider headache diary for 8 weeks
- Consider following **primary** headache causes
  - Migraine
  - Tension type headache
  - Analgesia overuse headache
- Consider other causes of primary headache that need **non-urgent referral to secondary care**:
  - Trigeminal autonomic cephalalgias e.g. cluster headache
  - New onset daily persistent headache (NODPH)
  - Other primary headache syndromes

For primary care management of headache, preferable to discuss cases with neurology SpR or neurology email advice service prior to undertaking MRI scanning – as headache alone is not marker of structural pathology, MRI findings can increase anxiety by revealing incidental findings and other imaging or investigation may be more appropriate.

See below for flow chart for management of headache in primary care

Flow Chart for Management of Headache in Primary Care



Author: Hannah Home, June 2014
Review date: June 2016