Neurology – Headache as a new complaint – Adult Patient Assessment Pathway

May 2010

NHS SCOTLAND

Patient Presentation

Headache

GP

Take detailed headache history and exclude serious causes:

- Intermittent or daily/persistent?
- How often and for how long do headaches last?
- Special days, seasons and times of day?
- Triggering and relieving factors?
- Site, nature and severity of pain?
- Nausea, photophobia, phonophobia, osmophobia, diarrhoea?
- Have to keep still or is restless?
- Lifestyle, missing meals, snack food, fizzy caffeinated drinks?
- Medication: including acute and preventor headache medication, all OTC medication. Frequency of analgesic use, use of oral contraceptive pill?

GP

Serious cause should be excluded

Suggested brief checklist that will highlight worrying signs & symptoms of conditions such as temporal arteritis, subarachnoid haemorrhage, meningitis, cerebral tumour:

- Waking with headache?
- Vomiting?
- Is frequency increasing?
- Was it very sudden onset (i.e. reached maximal intensity within 5 minutes)?
- Is there scalp tenderness?
- New headache in patient aged over 50 years?
- Do Valsalva manoeuvres precipitate headache?
- Past history of cancer?
- Recent change in behaviour/personality?

Worrying Focal Neurological signs:

- Papilloedema?
- Visual field defect?
- Pupil asymmetry?
- Eye movement disorder?
- Gait or speech disturbance?
- Reflex asymmetry?

Suggested brief examination:

- Temporal arteries for tenderness/normal pulsation?
- Fundoscopy?
- Eye movements?
- Temperature?
- Neck stiffness?
- Skin rash?
- Plantar responses?

GP

Primary headache?

Use findings from patient history and Table 1 to determine headache type and follow appropriate path on following pages for advice on management and referral criteria.

NB. Overuse of headache medication may itself mimic the primary headache it is used for.

GP

Secondary headache?

Other secondary cause?

E.g. sinusitis, temporomandibular joint problem, cervical spondylosis, severe hypertension.

GP

Manage appropriately.

Serious problem considered?

Features of: Subarachnoid haemorrhage, meningitis, signs of raised intracranial pressure.

No

Specialist Clinic

Urgent

Neurological/Medical referral as per local circumstances.

Yes

Hospital

Urgent same day

Neurological/Medical referral as per local circumstances.

Useful Information for Patients

NHS24: 08454 24 24 24

www.nhs.uk

www.doctoronline.nhs.uk

www.patient.co.uk

GP referred CT scan service should be accessed as per the existing GG&C protocol (see separate copy); where the headache is of greater than 3 month duration. If there are any concerns regarding a potential secondary cause for a headache of less than 3 months duration, that does not require urgent admission, then referral to secondary care should be made as described in the headache pathway

	Migraine	Tension type	Cluster	Other trigeminal autonomic cephalgias*	Cervicogenic	Medication overuse
Frequency	1-several/month	Variable	Every other day to 1–8 per day	Multiple daily	Daily for weeks	15 or more days in a month
Severity	Moderate–severe	Mild–moderate	Severe–very severe	Moderate–severe	Moderate–severe	Mild–severe
Location	Unilateral or bilateral	Bilateral	Unilateral	Unilateral in trigeminal distribution centred around eye	Posterior–unilateral	Bilateral (may mimic primary headache medication is used for)
Nature of pain	Throbbing/pulsating	Pressing/tightening	Severe unilateral pain	Severe – may be sometimes very brief	Ache radiating from neck/occipital region	Diffuse ache/pressure
Visual aura	+/- (present in a third of patients)	-	+/-	-	-	+/-
Duration	4–72 hours	Variable	15–180 minutes	Seconds – 30 min	Hours/constant	Hours/constant
Nausea	++	+/-	+/-	-	+/-	-
Photophobia	++	+/-	+ often ipsilateral	+/-	-	-
Vomiting	+	-	+/-	-	-	-
Activity	Keep still	Normal	Restless/pacing	Keep still or pace	Worse with neck movements/sleep & lifting	Normal
Examination	Normal	Tender points	Cranial autonomic features during attack	Cranial autonomic features during attack	Pain on neck movement and pressure	Normal
Suggested treatment						

Source: Scottish Government Task and Finish Group, 2010