How to survive the ten minute headache consultation

Dr David Kernick

St Thomas Medical Group

Exeter Headache clinic

Exeter Headache Clinic

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Making the Headache Diagnosis
Referral Pathways for Headache in Adults
Management Guidelines
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Research Activity and Publications
Headache Clinic Power Point Presentations
Support for NHS Commissioners
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BASH GPwSI Meeting Presentations
Headache Support Groups

St Thomas Medical Group in conjunction with the NHS South West Headache Network

This website offers support for Practitioners and information for patients

The Clinic
The Exeter Headache Clinic is operated by St Thomas Medical Group, an NHS General Practice. It has been in operation since 2002.

Clinic personnel
Dr David Kernick is a GP with a special interest in headache. He has a research interest in the area and has written a number of publications, including the Oxford University Press Manual of Headache. He was formerly the Chair of the British Association for the Study of Headache, and currently leads the Association's Headache Specialist General Practitioner Group.

Dr Peter Miller is a GP with a special interest in headache and has an interest in homeopathy. He is a member and former council member of the British Association for the Study of Headache.

Mrs Sam Hotton is the Clinic Manager.

Clinics
Clinics are held at St Thomas Health Centre, and occasionally at Exwick Health Centre.

Referral criteria
We have a contract to take referrals from practices within the NEW Devon CCG area (North, East and West Devon) for adults over the age of 18. This should be done through the e-Referral Service - specify Neurology and choose Headache Clinic (Dr David Kernick). Unfortunately we are unable to take referrals from outside Devon at the present time, due to pressures on the Clinic, and are unable to take private referrals. Our current waiting list is around 2 - 3 months.

We are not set up to deal with urgent referrals, but are happy to discuss cases in adults or children with GPs; either by email: sam.hotton@nhs.net, or telephone: 01392 676679.

Educational Role
We undertake undergraduate and postgraduate education. One of our primary aims is to improve the management of headache in primary care. We welcome healthcare professionals who may wish to join us for a headache clinic and are always happy to talk to GPs' surgery meetings. Contact Sam Hotton as above.

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Contact us
How to find us
Information for Prescribing Doctors for Prescribing Flunarizine

Cefaly

Consent form for GON injection

Greater Occipital Nerve Block

Information sheet for Amitriptyline

Information sheet for Atenolol

Information sheet for Candesartan

Information sheet for Emotional Freedom Technique

Information sheet For Flunarizine

Information sheet for Gabapentin

Information sheet for Indometacin

Information sheet for Lamotrigine

Information sheet for menstrual migraine

Information sheet for Metoclopramide /soluble Asprin/soluble Paracetamol

Information sheet on Mindfulness

Information sheet for patients taking Prednisolone

Information sheet for Propranolol

Information sheet for perimenopausal migraine

Information sheet on RESPeRATE therapeutic breathing device

Information sheet for Sodium Valproate

Information sheet for Topiramate

Topiramate for migraine in women of childbearing age

Information sheet for Triptans

Information on the vagal nerve stimulator

Information sheet for Verapamil

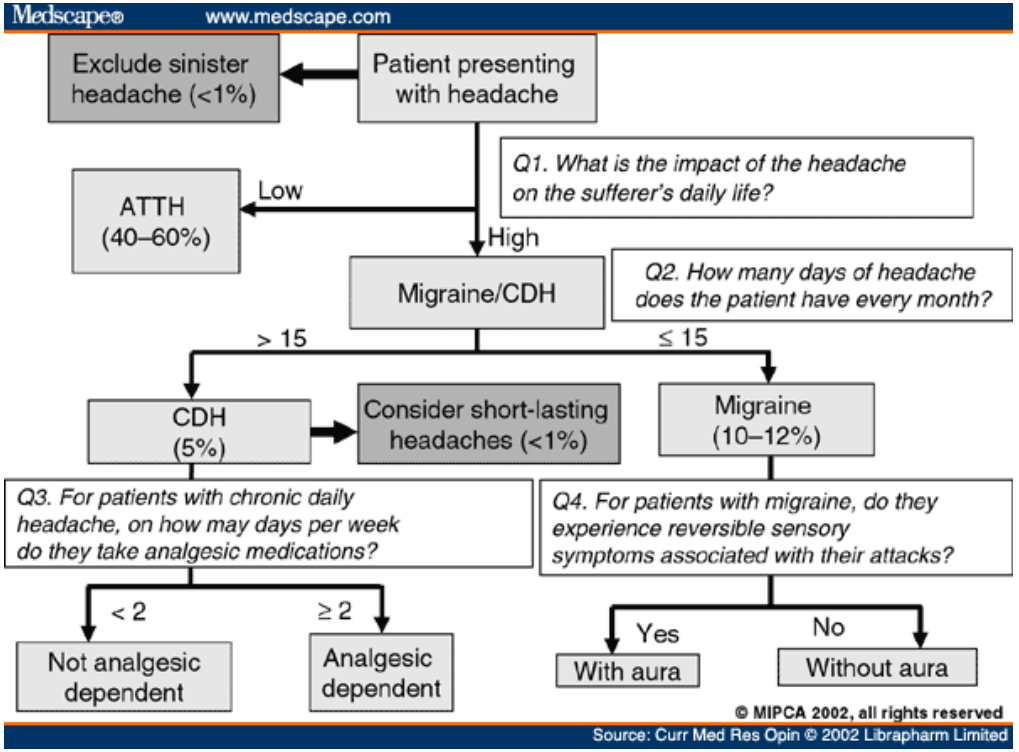
Information sheet for neck exercises

Headache Diary

Migraine - Frequently asked questions for patients and carers

Patient Information sheet for medication overuse headache




Medscape®
www.medscape.com
Exclude sinister headache (<1%)
Patient presenting with headache
Q1. What is the impact of the headache on the sufferer's daily life?
Low
ATTH (40–60%)
High
Migraine/CDH
Q2. How many days of headache does the patient have every month?
> 15
≤ 15
CDH (5%)
Consider short-lasting headaches (<1%)
Migraine (10–12%)
Q3. For patients with chronic daily headache, on how may days per week do they take analgesic medications?
Q4. For patients with migraine, do they experience reversible sensory symptoms associated with their attacks?
< 2
≥ 2
Not analgesic dependent
Analgesic dependent
Yes
No
With aura
Without aura
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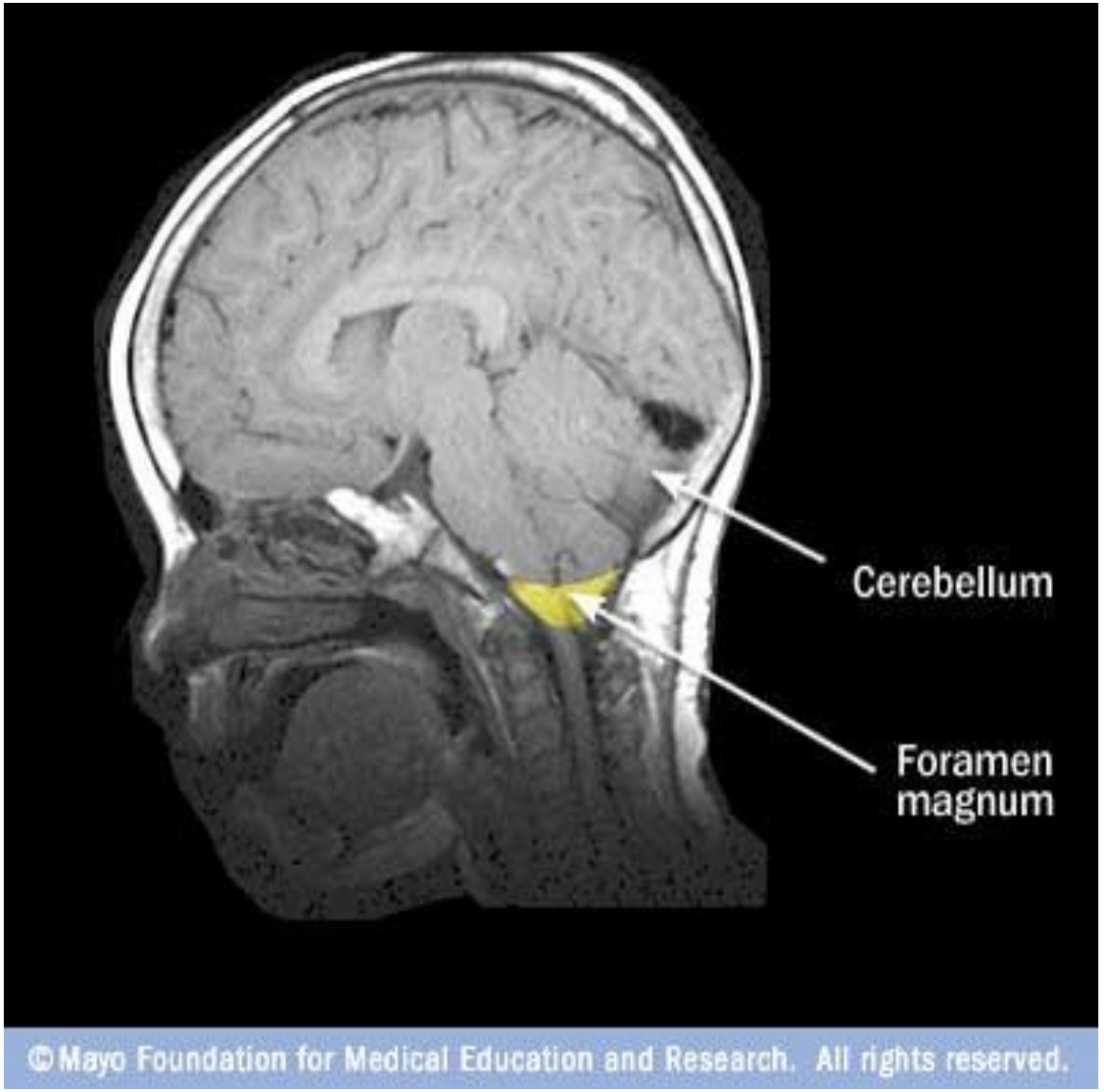
Source: Curr Med Res Opin © 2002 Librapharm Limited


All headache is migraine

Some secondary questions to think about

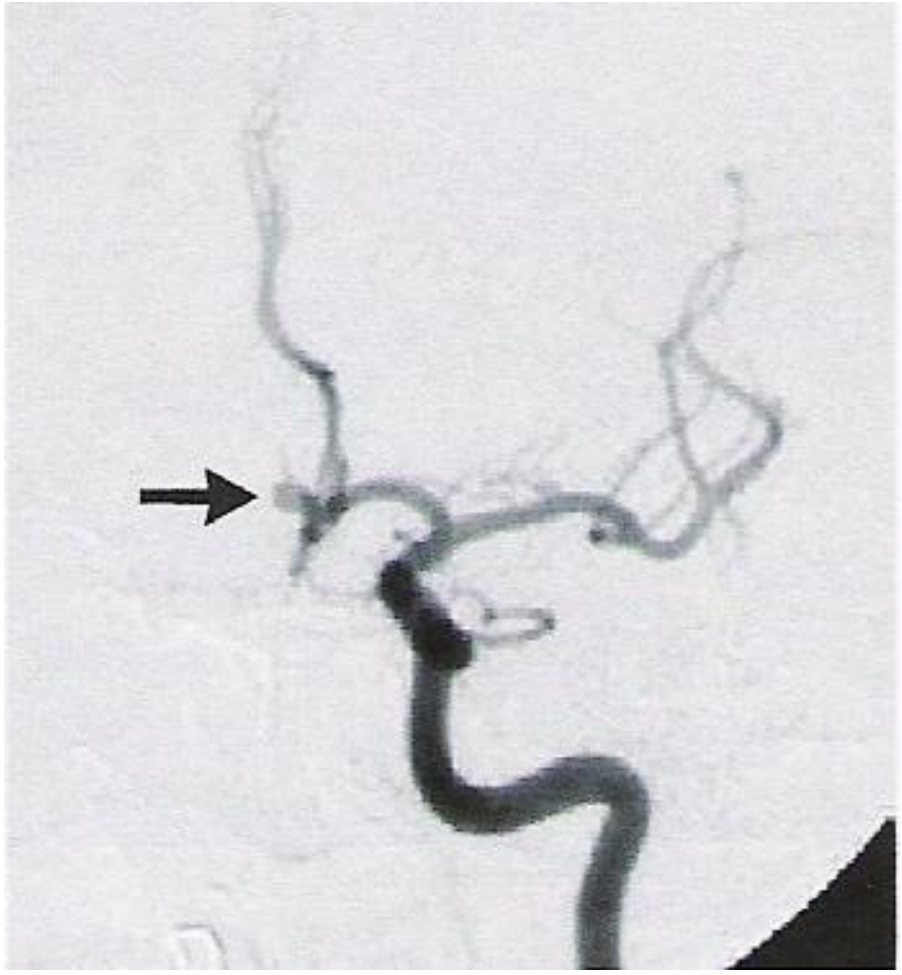
Exclude secondary headache

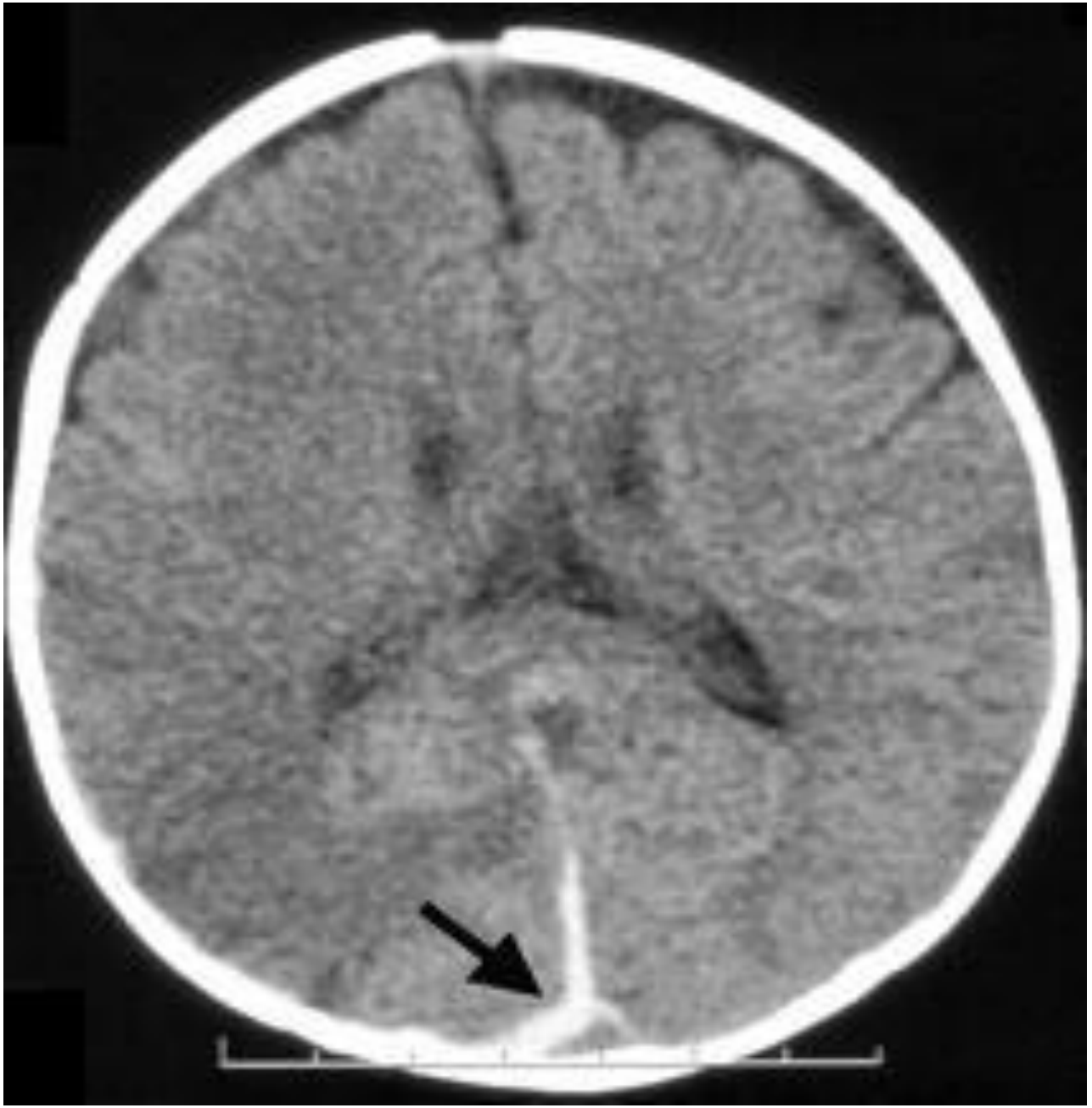
Diagnose a primary headache and exclude MOH



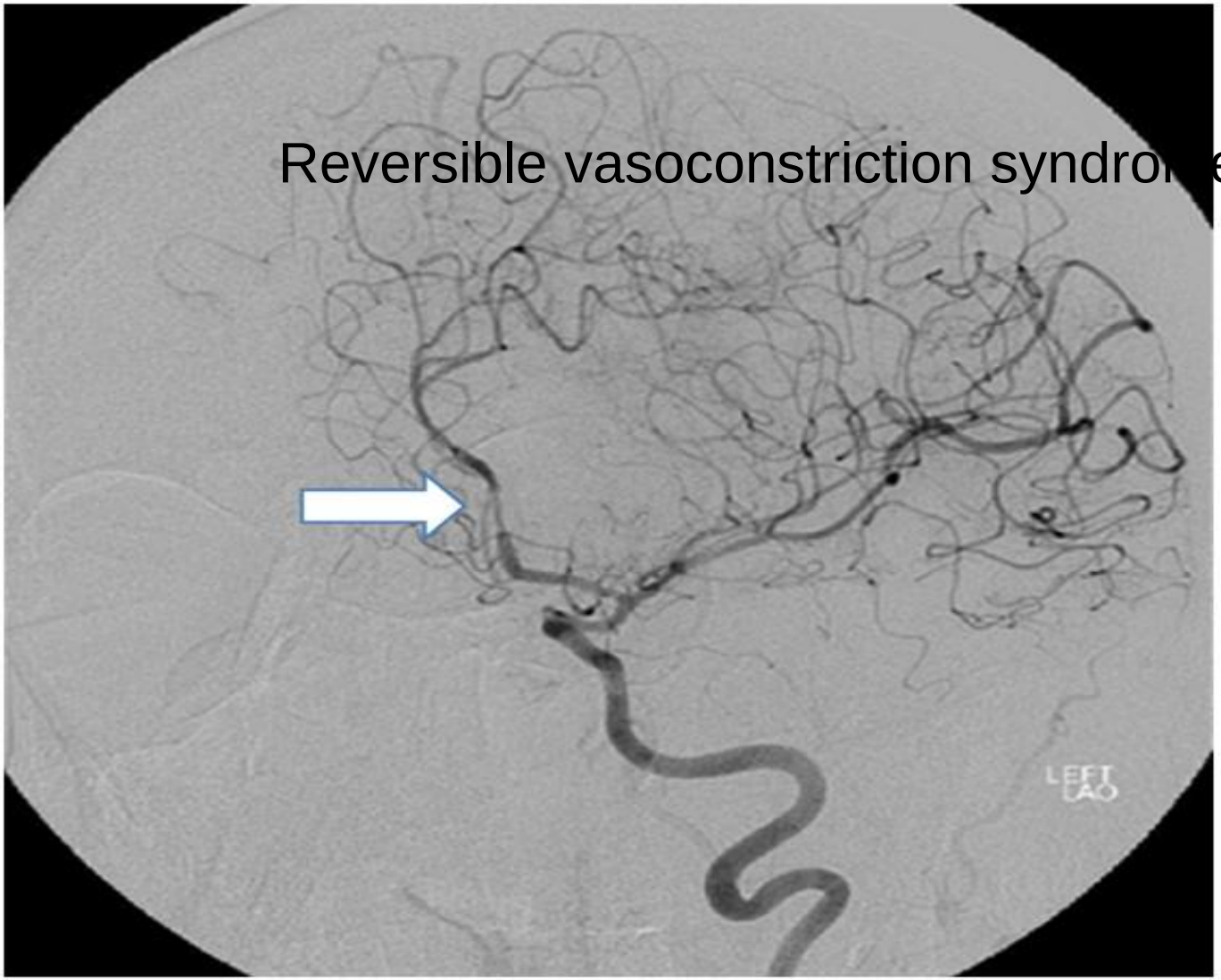
Pressure too low

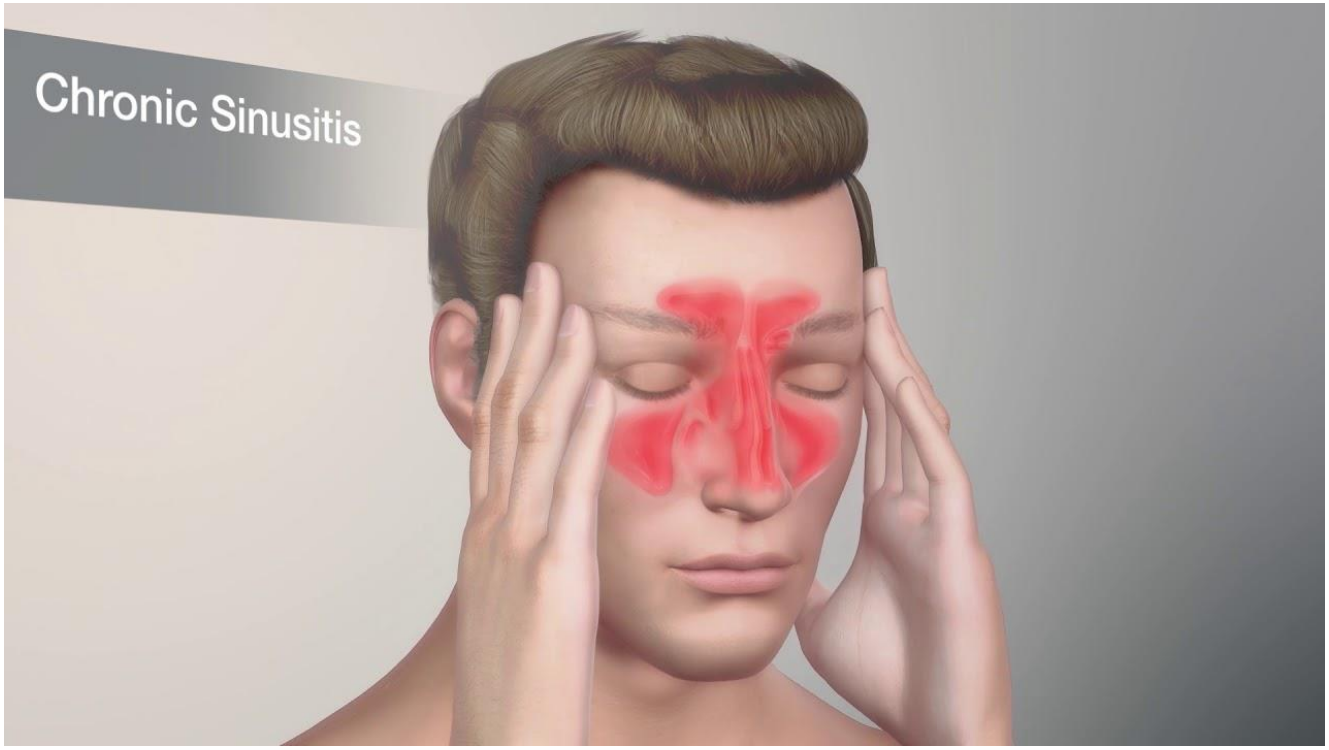
Sub Arachnoid - thunderclap headache



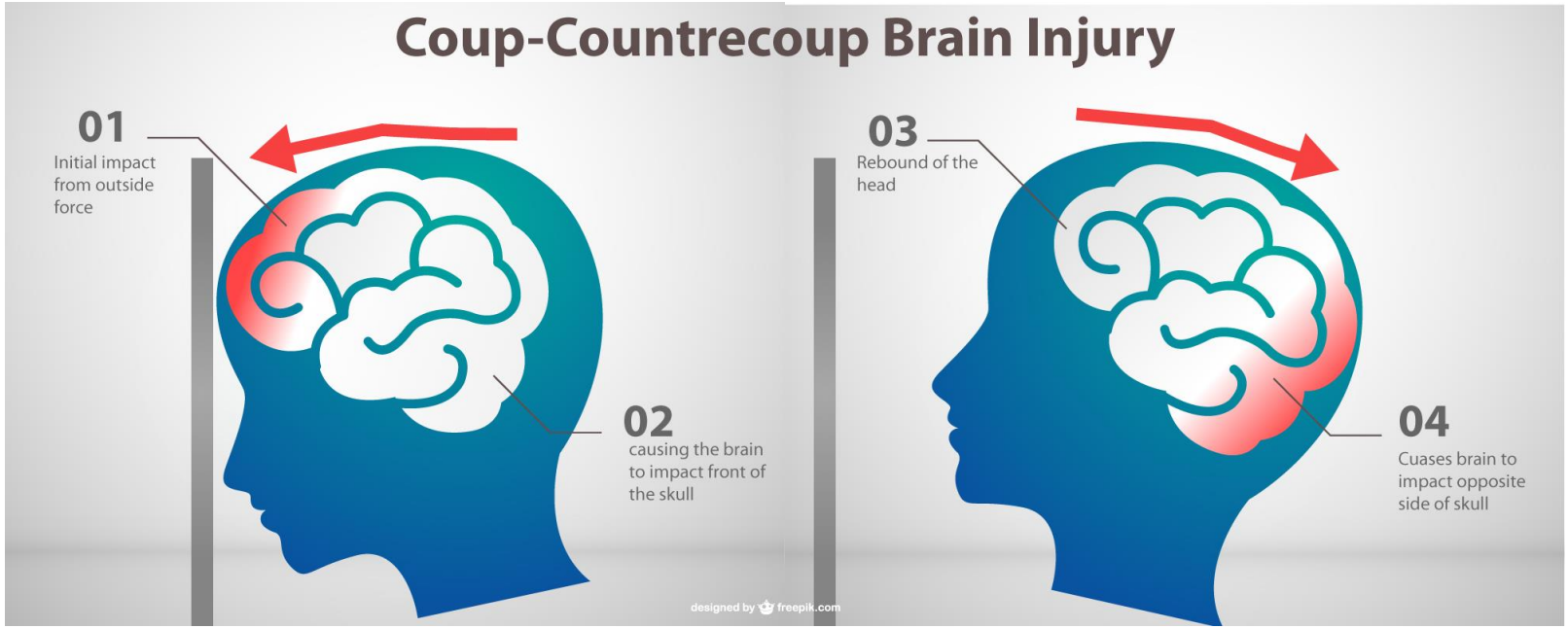


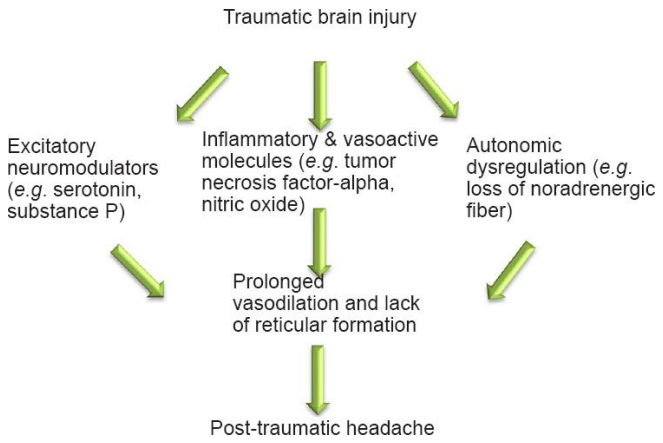
Reversible vasoconstriction syndrome

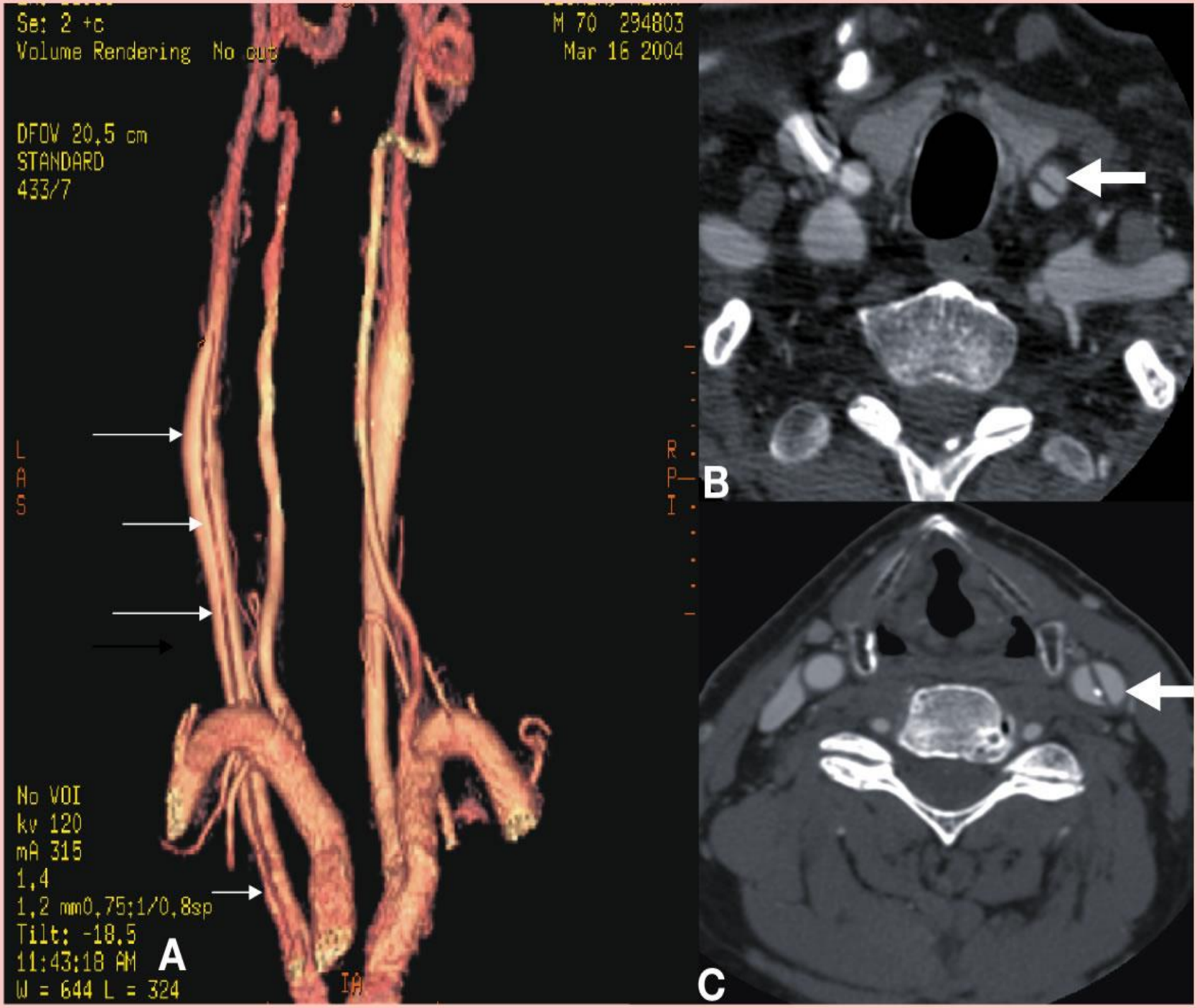




85% chronic sinusitis - migraine


Coup-Countrecoup Brain Injury
01
Initial impact from outside force
02
causing the brain to impact front of the skull
03
Rebound of the head
04
Cuases brain to impact opposite side of skull
designed by freepik.com


Traumatic brain injury
Excitatory neuromodulators (e.g. serotonin, substance P)
Inflammatory & vasoactive molecules (e.g. tumor necrosis factor-alpha, nitric oxide)
Autonomic dysregulation (e.g. loss of noradrenergic fiber)
Prolonged vasodilation and lack of reticular formation
Post-traumatic headache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Some secondary questions to think about

- Rapid onset
- Posture/raised pressure (coughing etc)
- Thrombophillia
- Vasoconstriction drugs
- Trauma
- Heating

Five key questions

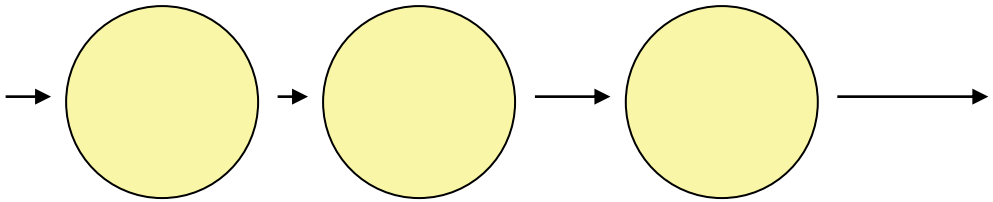
Two investigations

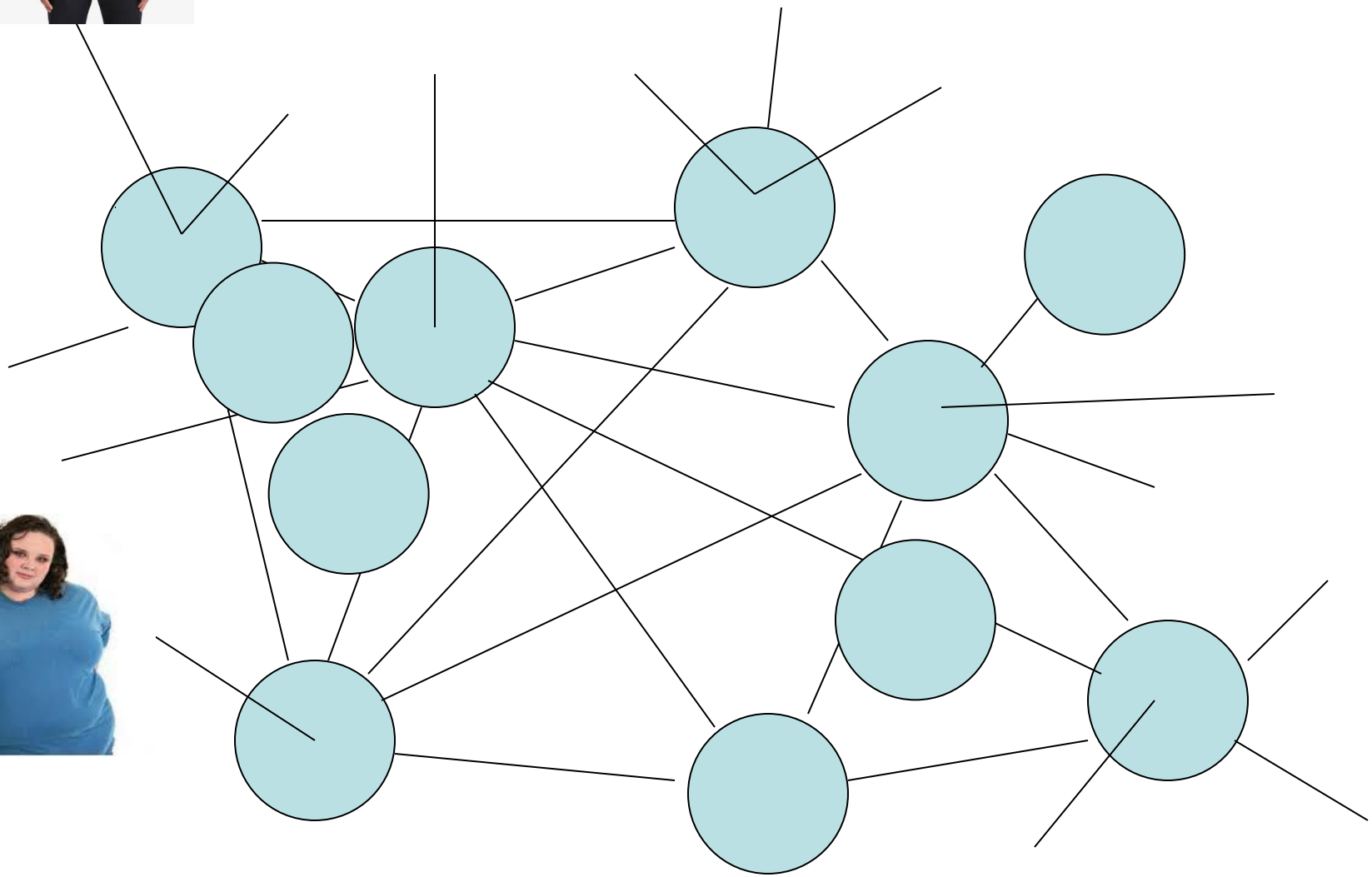
Two delaying tactics (Headache diary, blood tests)

One investigation (MRI)

- Headache bothering 3 weeks
- No clear features
- Otherwise well

- Headache 6 months. All over, dull, can be more severe, neck and shoulder pain. Jabbing.
- Muscle pains
- Dizzy attacks
- Not sleeping
- In danger of loosing her job
- Relationship issues with partner
- Friend had brain tumour





- Family history?

- Family history?
- How long?

- Family history?
- How long?
- What pain killers?

Daily paracetamol/codeine – Medication overuse headache

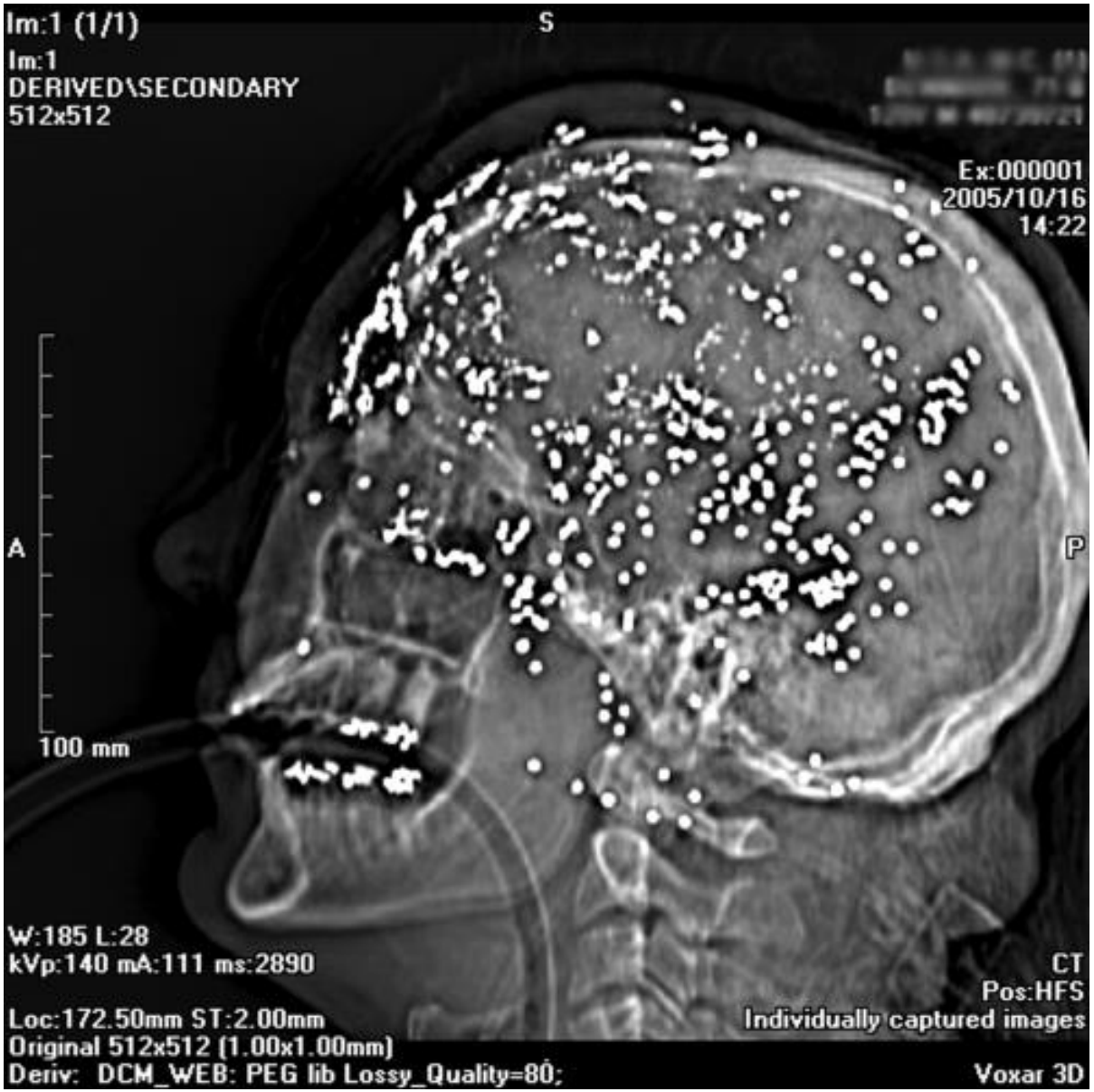
- Family history?
- How long?
- What pain killers?
- How many types of headache/what do you do?

1 “All over” - Medication overuse headache

2 “Can be severe” - Migraine without aura

3 “Jabbing” - Idiopathic stabbing headache

4 “Neck and shoulder pain” – low grade migraine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- Family history?
- How long?
- What pain killers?
- How many types of headache?
- Co-morbidities?

Migraine co-morbidities

- Anxiety
- Depression

- Vertigo
- IBS
- Fibromyalgia
- Asthma
- Epilepsy

•Headache 6 months. All over, dull, can be more severe, neck and shoulder pain. Jabbing. CHRONIC MIGRAINE WITH MOH

•Muscle pains FIBROMYALGIA

•Dizzy attacks VESTIBULAR MIGRAINE

•Not sleeping ANXIETY DEPRESSION

•In danger of loosing her job CERTIFICATE

•Relationship issues with partner JOINT CONSULTATION

•Brain tumour REASSURE

- Headache bothering 3 weeks
- No clear features
- Otherwise well

Strategy – allow a pattern to emerge

Examination

Headache is in the history

Examination In theory:

- For diagnosis
- To reassure the patient
- To connect with the patient
- To keep out of the law courts

Examination

Examination In practice:

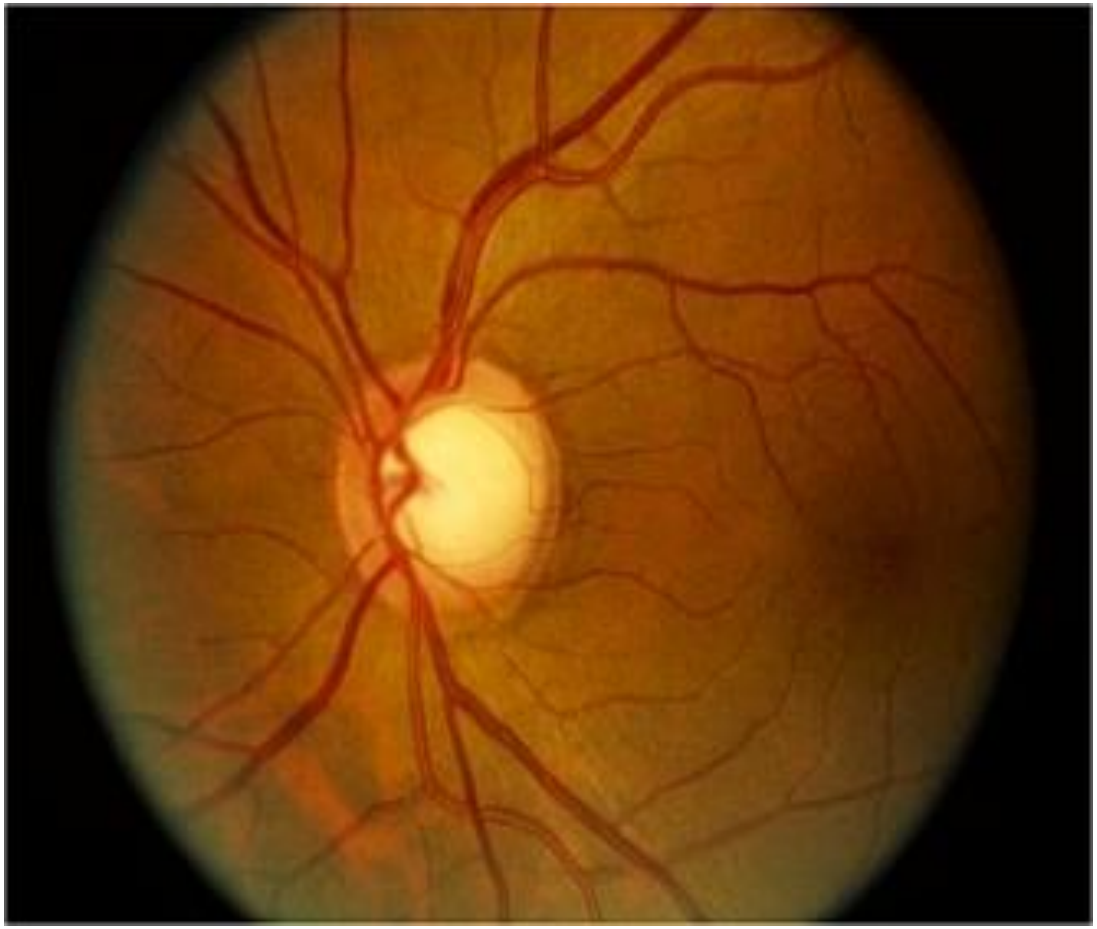
- To keep out of the law courts
- To connect with the patient
- To reassure the patient
- For diagnosis

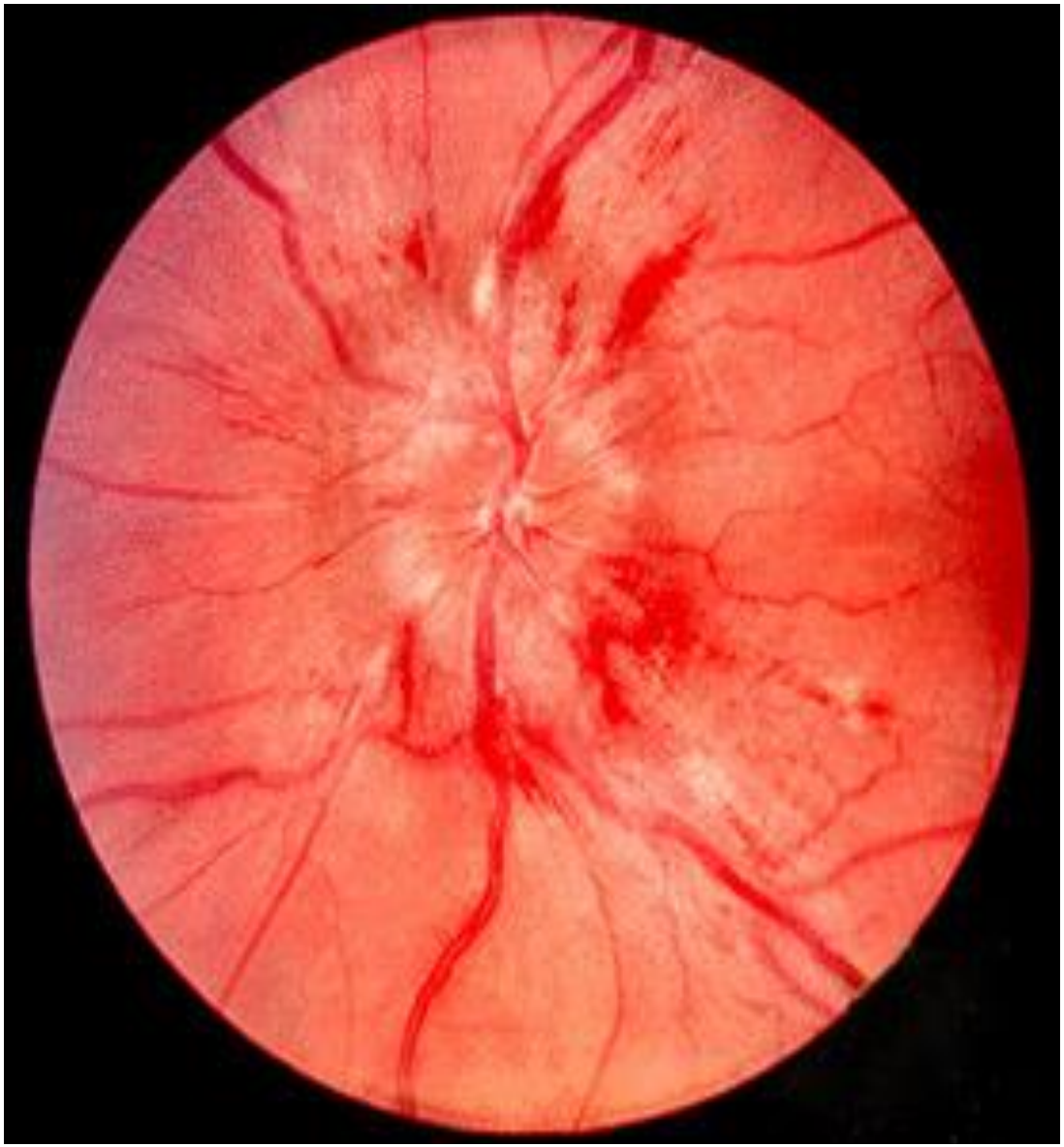
Undiagnosed headache

<u>Presentation</u>

- Family history?
- How long?
- What pain killers?
- How many types of headache/what do you do?
- Co morbidities

BP, Fundoscopy. Diary.





Undiagnosed headache

- <u>Presentation</u>
- Family history?
- How long?
- What pain killers?
- How many types of headache/what do you do?

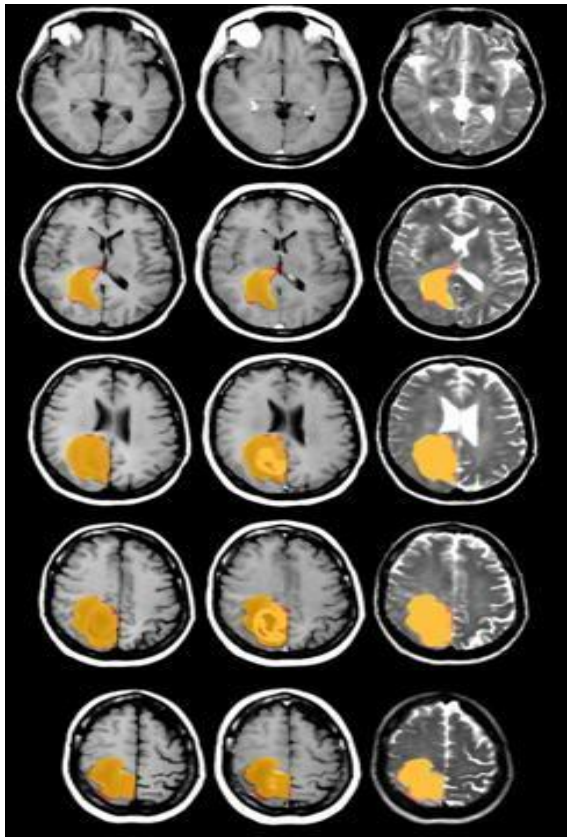
BP, Fundoscopy. Diary.

- <u>3-4 weeks -</u> 3 minute neurol examination. (Giles Elrington)
  Routine bloods. No specialist bloods unless clinically indicated
  (Eg. Anticardiolipin, anti nuclear antibodies)

- 6-8 weeks. Re examine. Discuss imaging.

Brain tumour – the problem

- Primary brain tumours 10/100,000 p.a
- A full-time GP - < one every five years.
- A full-time GP will expect to encounter the symptoms of possible brain tumours daily.



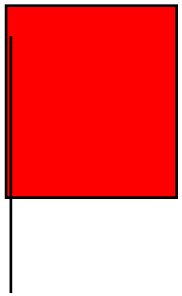
Headache and tumour

- Headache prevalence with tumour 70%+
- Headache at presentation 50%
- Headache alone at presentation 10%

(Iverson 1987)

Risk of brain tumour with headache presenting to primary care (Kernick 2008)

	Risk % (Background rate 0.01 %)	
	Undifferentiated headache	Primary headache
Under 50	0.09%	0.03%
Over 50	0.28%	0.09%

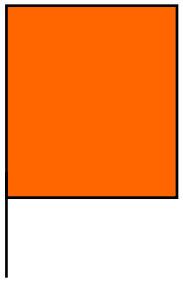


Red Flags

1%+

Headache with:

- Abnormal neurological symptoms or signs
- New seizure
- Headache with exercise
- History of cancer elsewhere



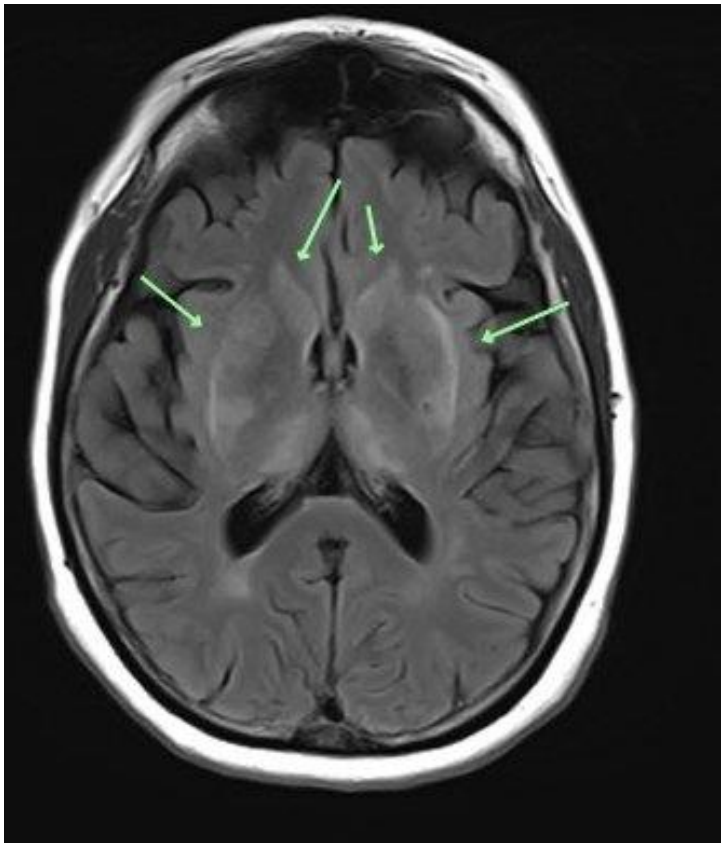
Orange Flags

0.1-1%. Careful monitoring

- Aggregated by Valsalva manoeuvre
- Headache with significant change in character
- Awakes from sleep
- New headache over 50 years
- Memory loss
- Personality change
- *If a primary headache diagnosis has not emerged in an isolated headache after 8 weeks*

Benefits/Dysbenefits MRI/CT

Incidentalomas 3-10%



- Headache bothering 3 weeks
- No clear features
- Otherwise well

- Don’t image for reassurrance NICE CG150

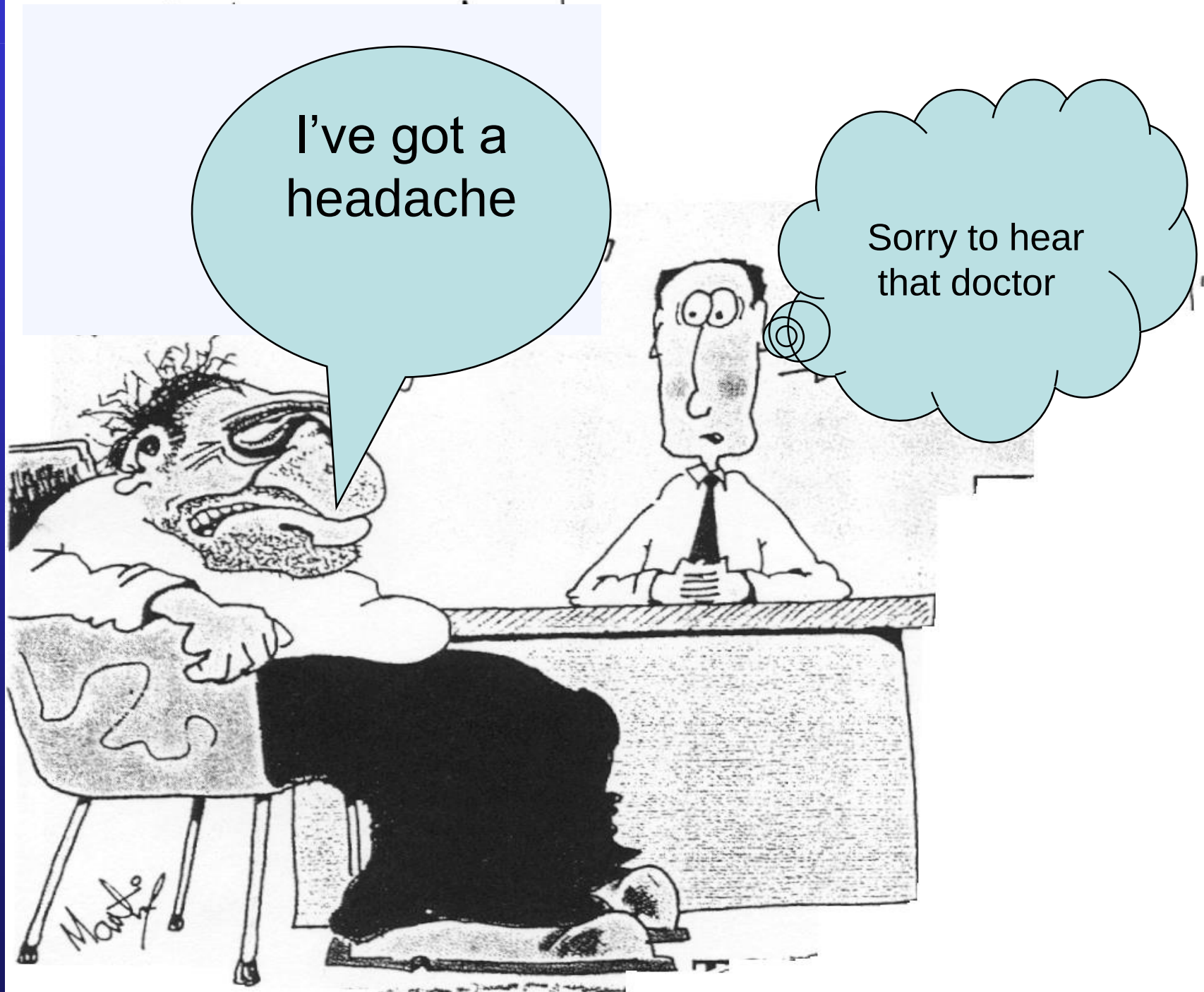


Five key questions

Two investigations

Two delaying tactics (Headache diary, blood tests)

One investigation (MRI)


I’ve got a headache
Sorry to hear that doctor