South West Peninsula Headache Network

Referral Pathways for Headache in Adults

This pathway covers the headache types most frequently encountered in practice

IMMEDIATE assessment required:

Ref Hospital

Thunder clap headache
Exclude subarachnoid haemorrhage

- Severe headache rising to maximum crescendo within a minute
- Worst ever headache

Headache associated with possible Meningo/encephalitis

Malignant hypertension

- Retinal changes
- BP > 200 systolic, 120 diastolic

Headache following major head injury

May require review

URGENT assessment required

Temporal arteritis

Check inflammatory markers

- Always consider in patients over 50 years
- Inflammatory markers are normal in 5% of cases.
- Urgent biopsy to confirm- within 2 weeks of starting steroids. If this diagnosis suspected generally most appropriate to start steroids and speak either to on call neurologist or on call surgical team to arrange temporal artery biopsy

Exercise headache / Cough headache
Image/scan

- 10% will have a secondary cause. MRI is generally the most appropriate imaging modality

Carbon monoxide poisoning

Measure CO-haemoglobin

- Non-specific headache
- Enquire re heating devices

DK May 2019

Venous sinus thrombosis Image/scan	• Non-specific progressive headache often frontal. May be symptoms of raised intracranial pressure and papilloedema • Most common in pregnancy and pro-thrombotic states. MRI/MRV is generally the most appropriate imaging modality
Space occupying lesion **Red flags (risk >1%)** Image/scan	• Associated relevant neurological signs • Associated with new onset seizure
Orange flags (risk >0.1%-1%) Need careful monitoring and low threshold for Image/scan or referral to GPwSI or neurologist	• Significant unexplained change in headache character • Migraine aura >1 hour • Headache precipitated by Valsalva manoeuvre • New headache in a patient older than 50 years • Headache that wakes from sleep (not migraine or cluster) • Headache where diagnosis can not be made 8 weeks from presentation • Primary cancer elsewhere • Immunosuppressed or HIV
Primary Headache (ie no structural cause)	
Exclude medication overuse headache If treatment resistant refer to GPwSI or neurologist with an interest. Difficult to manage and high relapse rate	• Any analgesia including Triptans taken on more than 3 days of the week on a regular basis • Non specific headache with a history of a prior primary headache • Can obscure diagnosis of primary headache
Cluster Refer to GPwSI or neurologist with an interest. MRI should be considered in all cases of new onset cluster headache. (Can be relaxed if stable cluster present for some time)	• Excruciating unilateral peri-orbital pain lasting up to 3 hours – the cluster attack • Unilateral autonomic features • Number of cluster attacks in a cluster period – classically 6-8 weeks • 10% are chronic

Migraine Refer to GPwSI or neurologist with an interest if: • Difficult to manage • Chronic migraine • Uncertain diagnosis	• Recurrent severe, unilateral or bilateral (30%) pain with or without aura lasting 4-72 hours (can be longer). • May be associated with nausea • May be associated with phonophobia, photophobia or movement sensitivity • Two out of three of following positive has high sensitivity: three months recurrent headache; associated with nausea; light sensitivity more pronounced with headache.
Tension type headache Refer to GPwSI or neurologist with an interest: • Difficult to manage • Uncertain diagnosis	• Dull, featureless, bilateral pain • Cause unknown but often associated with anxiety/depression • Reassurance and amitriptyline