HEADACHES

BELMATT
HEALTHCARE TRAINING

WORKBOOK

HEADACHE

This session aims to develop your skills in identifying primary and secondary headaches in primary care

OBJECTIVES

- Develop a structured approach to history taking in headache presentations in primary care.
- Understand the acronym SNOOP10 in identifying reds flags.
- Implement safe decision-making strategies to support you in recognising primary and secondary headaches.
- Recognise the importance of monitoring and support for patients with chronic headaches.

RECOMMENDED READINGS

- Bartley, R. and P. Coffey (2000) Management of Low Back Pain in Primary Care.
- Butterworth-Heinemann
- ISBN-10: 0750647876 ISBN-13: 978-0750647878
- Collins, (2017) Diagnosis and Management of Neck and Back Pain in
- Primary Care Paperback Lippincott Williams and Wilkins; 1 edition (1 Aug.
- 2017)
- ISBN-10: 1496362748 ISBN-13: 978-1496362742

HEADACHE

PC
HEADACHE

HPC
Site – unilateral (e.g. migraine) / frontal bilateral (e.g. tension headache)
Onset:
Was the onset acute or gradual? (sudden onset "thunderclap" headache is suggestive of subarachnoid haemorrhage)
For chronic headaches, in a month of 30 days, for how many of those days would the patient have a headache?
For how many days out of the month would the headache be severe?

Character – aching / throbbing / pounding / pulsating / pressure / pins and needles / stabbing

Radiation – neck (meningitis) / face (e.g. trigeminal neuralgia) / eye (e.g. acute closed angle glaucoma)

Associated symptoms:
1. Nausea/vomiting – may suggest raised intracranial pressure (ICP)
2. Visual disturbance – aura related / intracranial lesion / bleeding / stroke
3. Photophobia – raised ICP / meningitis
4. Neck stiffness – meningitis (may be related to infection or subarachnoid haemorrhage)
5. Fever – suggestive of an infective process (e.g. bacterial meningitis/abscess)
6. Rash – non-blanching purpuric rash may indicate meningococcal sepsis (not relevant given the duration of this patient's symptoms.)
7. Weight loss – suggestive of malignancy – consider cerebral metastases
8. Sleep disturbance – headaches causing sleep disturbance are concerning (raised ICP)
9. Temporal region tenderness – consider temporal arteritis
10. Neurological deficits – weakness / sensory disturbance / impaired coordination / cognitive symptoms / altered level of consciousness – consider space-occupying lesions / intracranial bleeding / stroke

Timing – Duration of headache? / Recurrent? / Is it episodic? / Pattern? / Diurnal variation?

Exacerbating/relieving factors:
Exacerbating factors – are there any obvious triggers for the symptom? (e.g. caffeine / codeine / stress / postural change)
Relieving factors – does anything appear to improve the symptoms (e.g. improvement upon lying flat suggestive of reduced ICP).

Severity:
• Ask the patient to rate the pain on a scale of 1-10
• Is the pain getting worse?
• How is it impacting their daily life?

PMH

1. Onset, duration, frequency and temporal pattern (episodic, daily or unremitting).
2. Pain characteristics including severity, site and spread of pain.
3. Associated symptoms such as:
a. Aura (visual, auditory or gustatory disturbance), nausea, photophobia and intolerance of noise — may indicate migraine.
b. Autonomic features for example tearing, drooping or swollen eyelid, pain around one eye, nasal congestion or rhinorrhoea
c. Systemic and neurological features such as fever, neck stiffness, weakness and visual disturbance.
4. Contacts with similar symptoms.
a. Consider possible carbon monoxide poisoning if household contacts or pets have similar symptoms.
5. Precipitating and relieving factors such as: Trauma, posture, Valsalva manoeuvres, fatigue or stress, menstrual cycle, and medication change or withdrawal.

MEDICATION

1. Take comprehensive drug history is necessary to identify potential secondary causes of headache such as
intracranial bleeding or medication overuse.
2. Drugs such as methamphetamines, cocaine, anticoagulants and glucocorticoids can increase the risk of stroke/ intracranial bleeding
3. Medication overuse headache can be due to overuse of ergotamines, triptans, simple analgesics and opioids

Regular prescribed medication?
Anticoagulants or anti-platelets? – e.g. Warfarin / Aspirin
Analgesia for headache?
• Clarify dosages and frequencies
• In a month with 30 days, on how many days would they use painkillers?
• Do the painkillers fully relieve the pain?
Over the counter drugs or herbal remedies?

ALLERGIES

Check if allergies could have contributed to the headache.

FAMILY HISTORY

Neurological diagnoses in first degree relatives? – e.g. migraine

FAMILY HISTORY

Smoking – How many cigarettes a day? How long have they smoked for?
Alcohol – How many units a week? – be specific about type / volume / strength of alcohol
Recreational drug use – headache may be withdrawal related

Living situation:
- House / Flat – stairs/adaptations
- Who lives with the patient? – important when considering discharging home from the hospital
- Any carer input? – what level of care do they receive?

Activities of daily living:
- Is the patient independent / able to fully care for themselves?
- Can they manage self-hygiene/housework/food shopping?
- Is the headache interfering significantly with their daily life?

Occupation – clarify their role and daily responsibilities

SYSTEMIC ENQUIRY

Systemic enquiry involves performing a brief screen for symptoms in other body systems. This may pick up on symptoms the patient failed to mention in the presenting complaint. Some of these symptoms may be relevant to the diagnosis (e.g. neck stiffness in meningitis). Choosing which symptoms to ask about depends on the presenting complaint and your level of experience.
Cardiovascular – Chest pain / Palpitations / Dyspnoea / Syncope / Orthopnoea / Peripheral oedema
Respiratory – Dyspnoea / Cough / Sputum / Wheeze / Haemoptysis / Chest pain
GI – Appetite / Nausea / Vomiting / Indigestion / Dysphagia / Weight loss / Abdominal pain / Bowel habit
Urinary – Volume of urine passed / Frequency / Dysuria / Urgency / Incontinence
Musculoskeletal – Bone and joint pain / Muscular pain
Dermatology – Rashes / Skin breaks / Ulcers / Lesions

EXAMINATION

1. Vital signs
Assess blood pressure, pulse, respiration rate, temperature and oxygen saturation levels.

2. General appearance and mental state
Look for signs of serious causes of headache such as skin rash, changes in level of consciousness or confusion.

3. Extracranial structures
Assess the carotid arteries, temporal arteries, sinuses and temporomandibular joints.

4. The neck
Look for signs of meningeal irritation, tenderness of cervical paraspinal muscles, limitation in range of movement and crepitation.

5. Neurology
a. Fundoscopy (looking for papilloedema, pupillary asymmetry and reactivity) and cranial and peripheral nerve examination including gait.
b. Examination should be normal with primary or benign causes of headache — if abnormal, refer the patient

INVESTIGATION

- Investigations are generally not required to diagnose primary headache.
- If there are any red flags or a serious cause of headache is suspected refer the person to
- secondary care for further assessment with urgency depending on the clinical situation.
- If the diagnosis is not clear and serious causes of headache have been ruled out:

a. Arrange review and ask the person to keep a diary over a few weeks to record frequency, duration and severity of headaches; associated symptoms; all prescribed and over the counter medications taken to relieve headaches; and possible triggers.
If the diagnosis remains unclear seek advice from a specialist in neurology.

TENSION-TYPE HEADACHE

Consider tension type headache if:
1. The person has recurrent episodes of headache lasting from 30 minutes to 7 days which is not associated with nausea or vomiting (the headache may also be associated with no more than one of photophobia or phonophobia)
and
2. The headache has at least two of:

- Bilateral location.
- Pressing or tightening (non-pulsating) quality.
- Mild or moderate intensity.
- Not aggravated by routine physical activity such as walking or climbing stairs.

ACUTE TREATMENT PROPHYLACTIC TREATMENT

Consider aspirin, paracetamol or an NSAID for the acute treatment of tension-type headache, taking into account the person's preference, comorbidities and risk of adverse events.
Do not offer opioids for the acute treatment of tension-type headache.
Consider a course of up to 10 sessions of acupuncture over 5–8 weeks for the prophylactic treatment of chronic tension-type headache.

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CLUSTER HEADACHE

Consider cluster headache if:

1. The person has had at least five attacks of severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15–180 minutes and
2. The headache is associated with at least one of: ipsilateral conjunctival injection and/or lacrimation; nasal congestion and/or rhinorrhoea; eyelid oedema; forehead and facial sweating; forehead and facial flushing; sensation of fullness in the ear; or miosis and/or a sense of restlessness or agitation.
3. Attacks occur between one every other day and eight per day for more than half of the time when the disorder is active.

ACUTE TREATMENT

Discuss the need for neuroimaging for people with a first bout of cluster headache with a GP with a special interest in headache or a neurologist
Offer oxygen and/or a subcutaneousor nasal triptan for the acute treatment of cluster headache.

When using oxygen for the acute treatment of cluster headache:

- use 100% oxygen at a flow rate of at least 12 litres per minute with a non-rebreathing mask and a reservoir bag and
- arrange provision of home and ambulatory oxygen.

PROPHYLACTIC TREATMENT

When using a subcutaneous or nasal triptan , ensure the person is offered an adequate supply of triptans calculated according to their history of cluster bouts, based on the manufacturer's maximum daily dose.
Do not offer paracetamol, NSAIDS, opioids, ergots or oral triptans for the acute treatment of cluster headache
Consider verapamil for prophylactic treatment during a bout of cluster headache. If unfamiliar with its use for cluster headache, seek specialist advice before starting verapamil, including advice on electrocardiogram monitoring.Seek specialist advice for cluster headache that does not respond to verapamil
Seek specialist advice if treatment for cluster headache is needed during pregnancy.

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MEDICATION OVERUSE HEADACHE

Explain to people with medication overuse headache that it is treated by withdrawing overused medication
Advise people to stop taking all overused acute headache medications for at least 1 month and to stop abruptly rather than gradually
Advise people that headache symptoms are likely to get worse in the short term before they improve and that there may be associated withdrawal symptoms, and provide them with close follow-up and support according to their needs
Consider prophylactic treatment for the underlying primary headache disorder in addition to withdrawal of overused medication for people with medication overuse headache.
Do not routinely offer inpatient withdrawal for medication overuse headache.
Consider specialist referral and/or inpatient withdrawal of overused medication for people who are using strong opioids, or have relevant comorbidities, or in whom previous repeated attempts at withdrawal of overused medication have been unsuccessful
Review the diagnosis of medication overuse headache and further management 4–8 weeks after the start of withdrawal of overused medication.

MENSTRUAL-RELATED MIGRAINE

Suspect menstrual-related migraine in women and girls whose migraine occurs predominantly between 2 days before and 3 days after the start of menstruation in at least 2 out of 3 consecutive menstrual cycles.
Diagnose menstrual-related migraine using a headache diary for at least 2 menstrual cycles.

TREATMENT

For women and girls with predictable menstrual-related migraine that does not respond adequately to standard acute treatment, consider treatment with frovatriptan (2.5 mg twice a day) or zolmitriptan (2.5 mg twice or three times a day) on the days migraine is expected

MIGRAINE WITH AURA

Consider migraine without aura if the person has had at least five attacks fulfilling the following
criteria:

1. Headache attacks lasting 4-72 hours (untreated or unsuccessfully treated).
2. The headache has at least two of the following four characteristics:

- Unilateral location.
- Pulsating quality.
- Moderate or severe pain intensity.
- Aggravation by or causing avoidance of routine physical activity (for example walking or climbing stairs).
- During headache at least one of following; nausea and/or vomiting; photophobia and phonophobia.

Suspect aura in people who present with or without headache and with neurological symptoms that:

- are fully reversible and
- develop gradually, either alone or in succession, over at least 5 minutes and
- last for 5–60 minutes.

Diagnose migraine with aura in people who present with or without headache and with one or more of the following typical aura symptoms that meet the criteria in recommendation

- visual symptoms that may be positive (for example, flickering lights, spots or lines) and/or negative (for example, partial loss of vision)
- sensory symptoms that may be positive (for example, pins and needles) and/or negative (for example, numbness)
- speech disturbance.

Consider further investigations and/or referral for people who present with or without migraine headache and with any of the following atypical aura symptoms that meet the criteria in recommendation

- motor weakness or
- double vision or
- visual symptoms affecting only one eye or
- poor balance or
- decreased level of consciousness.

MIGRAINE WITH AURA

Consider migraine with aura if the person has had at least two attacks fufilling the following criteria:

1. One or more of the following fully reversible aura symptoms:
- Visual symptoms such as zigzag lines and/or scotoma— visual aura is the most common type of aura.
- Sensory symptoms such as pins and needles.
- Speech and/or language symptoms such as aphasia.
- Motor weakness.
- Brainstem symptoms such as vertigo or diplopia.
- Retinal symptoms such as monocular scintillations or scotoma.

2. At least two of the following four characteristics:
- At least one aura symptom spreads gradually over at least 5 minutes, and/or two or more symptoms occur in succession.
- Each individual aura symptom lasts 5-60 minutes.
- At least one aura symptom is unilateral.
- The aura is accompanied, or followed within 60 minutes, by headache.

ACUTE TREATMENT

Offer combination therapy with an oral triptan
and an NSAID, or an oral triptan[9] and paracetamol, for the acute treatment of migraine, taking into account the person's preference, comorbidities and risk of adverse events. For young people aged 12–17 years consider a nasal triptan in preference to an oral triptan. [2012]

For people who prefer to take only one drug, consider monotherapy with an oral triptan, NSAID, aspirin (900 mg) or paracetamol for the acute treatment of migraine, taking into account the person's preference, comorbidities and risk of adverse events.

When prescribing a triptan[9] start with the one that has the lowest acquisition cost; if this is consistently ineffective, try one or more alternative triptans.

Consider an anti-emetic in addition to other acute treatment for migraine even in the absence of nausea and vomiting.

Do not offer ergots or opioids for the acute treatment of migraine.

For people in whom oral preparations (or nasal preparations in young people aged 12–17 years) for the acute treatment of migraine are ineffective or not tolerated:
offer a non-oral preparation of metoclopramide[10] or prochlorperazine[11] and
consider adding a non-oral NSAID or triptan[9] if these have not been tried.

PROPHYLACTIC TREATMENT

Offer topiramate or propranolol[12] for the prophylactic treatment of migraine according to the person's preference, comorbidities and risk of adverse events. Advise women and girls of childbearing potential that topiramate is associated with a risk of fetal malformations and can impair the effectiveness of hormonal contraceptives. Ensure they are offered suitable contraception if needed.

Consider amitriptyline[13] for the prophylactic treatment of migraine according to the person's preference, comorbidities and risk of adverse events.
Do not offer gabapentin for the prophylactic treatment of migraine.

If both topiramate and propranolol[12] are unsuitable or ineffective, consider a course of up to 10 sessions of acupuncture over 5–8 weeks according to the person's preference, comorbidities and risk of adverse events.

For people who are already having treatment with another form of prophylaxis and whose migraine is well controlled, continue the current treatment as required.

Review the need for continuing migraine prophylaxis 6 months riboflavin (400 mg once a day) may be effective in reducing migraine frequency and intensity

Combined hormonal contraceptive use by women and girls with migraine
Do not routinely offer combined hormonal contraceptives for contraception to women and girls who have migraine with aura.

DIFFERENTIAL DIAGNOSIS

Headache is a common symptom which can be associated with many conditions. **The differential diagnosis depends on the clinical picture and includes:**

1. Headache not associated with an underlying condition – primary headache:
a. Migraine.
b. Tension-type headache.
c. Trigeminal autonomic cephalgias for example cluster headache and paroxysmal hemicranias.
d. Other primary headache disorders such as primary cough headache and cold-stimulus headache.

2. Secondary headaches — headache attributed to an underlying condition including:
a. Trauma or injury to the head and/or neck.
b. Cranial or cervical vascular disorders for example intracerebral haemorrhage, central venous thrombosis or giant cell arteritis.
c. Non-vascular intracranial disorders for example idiopathic intracranial hypertension or neoplasm.
d. Exposure to, or withdrawal from, a substance such as carbon monoxide, cocaine or alcohol — medication overuse headache (which can be due to ergotamines, triptans, simple analgesics and opioids) is included in this category.
e. Infection for example intracranial infection (including meningitis, encephalitis and cerebral abscess) or systemic infection.
f. Disorders of homeostasis for example hypoxia or hypertension including pre-eclampsia and eclampsia.
g. Disorders of the cranium, neck, eyes, ears, nose, sinuses, teeth, mouth or other facial or cranial structure such as angle closure glaucoma, temporomandibular disorder, dental problems, otitis media or sinusitis.
h. Psychiatric disorders such as somatization disorder.

3. Painful cranial neuropathies and other facial pains such as trigeminal neuralgia, post-herpetic neuralgia and optic neuritis.

RED FLAGS

A headache of sudden onset, reaching maximum intensity by five minutes (suggestive of subarachnoid haemorrhage)

1. Fever with a worsening headache, meningeal irritation and change in mental status (viral/bacterial meningitis)
2. New-onset focal neurological deficit, personality change or cognitive dysfunction(intracranial haemorrhage/ ischaemic stroke/space occupying lesion)
3. Decreased level of consciousness
4. Head trauma (more significant if within the last three months)
5. Headache which is posture dependent (e.g. worse on lying down and coughing with raised ICP).
6. Headache associated with tenderness in the temporal region (unilateral or bilateral) and jaw claudication (temporal arteritis)
7. Headache associated with severe eye pain/blurred vision/nausea/vomiting/red eye (acute angle closure glaucoma

Warning features for serious secondary headache disorders that require emergency or urgent referral to secondary care include:

1. New severe or unexpected headache:
a. Sudden-onset severe headache reaching maximum intensity within 5 minutes may indicate serious causes such as intracranial haemorrhage, venous sinus thrombosis, hypertensive encephalopathy and vertebral artery dissection.

b. New onset headache in a person aged over 50 years may indicate a serious cause such as giant cell arteritis or space occupying lesion.

2. Progressive or persistent headache or headache that has changeddramatically:
a. Consider serious causes such as mass lesion or subdural haematoma.

3. Associated features such as:
a. Fever, impaired consciousness, seizure, neck pain/stiffness or photophobia — consider serious causes such as meningitis and encephalitis.
b. Papilloedema — consider space occupying lesions, cerebral venous sinus thrombosis and benign intracranial hypertension.

c. New-onset neurological deficit, change in personality and new-onset cognitive dysfunction consider serious causes such as a cerebrovascular event, malignancy or other space occupying lesions such as subacute or chronic subdural hematoma.
d. Atypical aura (duration greater than 1 hour, or including motor weakness) or aura occurring for the first time in a patient during use of combined oral contraceptives — consider serious causes such as cerebrovascular event.
e. Dizziness — consider serious causes such as ischaemic or haemorrhagic stroke.
f. Visual disturbance — can be associated with migraine but also with serious causes such as acute closure glaucoma and temporal arteritis.
Vomiting — can associated with migraine but may also be associated with a serious cause of headache such as mass lesion, brain abscess, or carbon monoxide poisoning.

ALL HEADACHE DISORDERS

Consider using a headache diary:

- to record the frequency, duration and severity of headaches
- to monitor the effectiveness of headache interventions
- as a basis for discussion with the person about their headache disorder and its impact. [

Consider further investigations and/or referral if a person diagnosed with a headache disorder develops any of the features listed in recommendation
Do not refer people diagnosed with tension-type headache, migraine, cluster headache or medication overuse headache for neuroimaging solely for reassurance.

Information and support for people with headache disorders
Include the following in discussions with the person with a headache disorder:

- a positive diagnosis, including an explanation of the diagnosis and reassurance that other pathology has been excluded and
- the options for management and
- recognition that headache is a valid medical disorder that can have a significant impact on the person and their family or carers.

Give the person written and oral information about headache disorders, including information about support organisations.
Explain the risk of medication overuse headache to people who are using acute treatments for their headache disorder

TREATMENT OF MIGRAINE DURING PREGNANCY

Offer pregnant women paracetamol for the acute treatment of migraine. Consider the use of a triptan or an NSAID after discussing the woman's need for treatment and the risks associated with the use of each medication during pregnancy.
Seek specialist advice if prophylactic treatment for migraine is needed during pregnancy.

QUALITY STANDARDS ON HEADACHES IN THE OVER 12S

The following are included in the National Institute for Health and Care Excellence (NICE) Quality

Standards on Headaches in the over 12s

STATEMENT 1	People diagnosed with a primary headache disorder have their headache type classified as part of the diagnosis.
STATEMENT 2	People with a primary headache disorder are given information on the risk of medication overuse headache.
STATEMENT 3	People with tension-type headache or migraine are not referred for imaging if they do not have signs or symptoms of secondary headache.
STATEMENT 4	People with migraine are advised to take combination therapy with a triptan and either a non- steroidal anti-inflammatory drug (NSAID) or paracetamol.
STATEMENT 5	Raising public and professional awareness. This is a placeholder statement intended to be updated when relevant evidence is published.

Raising public and professional awareness of primary headache disorders has the potential to improve the quality of life for young people and adults with a primary headache disorder.

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QUIZ

1. What is a primary and what is a secondary headache?

_____
_____

2. Name the 4 types of primary headaches

a. _____
b. _____
c. _____
d. _____

3. What are the 2 types of migraine headaches

_____
_____

4. 15yr old attends the surgery with her mum complaining of migraines. Pain starts at the back then spreads to temples and forehead. She feels tired when headache starts, gets blurry vision and very moody according to her mum. Headache for 14hrs now. no abnormal neurology. Complaining of seeing zigzaggy lines with blind spots. This happens when headache is worse and lasts about 30minutes then gets better. Differentials and how would u treat.

a. Which anti emetics can you give and why?

_____
_____

b. Pt states that analgesia and triptans not working. Why should u not take a triptan when you are having an aura?

_____
_____

c. Why do we monitor ECG in pts on amitriptyline?

_____
_____

d. What is a tension type headache?

_____
_____

HEADACHE SCENARIOS

Steve is 46 and presents to you with a 15 year history of headaches. These are bi-temporal, throbbing and last less than one hour. They are not associated with photophobia, phonophobia, nausea or vomiting. In the last 5 months he has had a metallic taste in his mouth for roughly 20 minutes followed by visual disturbances that he describes as 'looking through water'. Associated symptoms include tingling of his left hand and the left side of his tongue, followed by numbness in his left leg. Headaches always follow after these numbness and taste episodes. After 30 minutes all of the symptoms resolve. He has had headaches 3 times a month for the last five months. Roughly one year ago he had an episode of slurred speech and tingling in his left hand and tongue which resolved and never recurred.
His appetite, weight and energy are all normal and he has no significant past medical history.

- How would you ensure your history taking was systematic?
- Which mnemonics might you use?
- What would you include in your ROS?

On examination

- Finger rub test on left ear showed some loss of hearing
- No visual deficits
- Reflexes all within normal limits
- No history of depression, anxiety, hypertension or trauma
- FH of migraines, IHD and cancer

What neuro. examination might you conduct. What can you rule out with such an examination?

_____
_____

If you decided to refer who would you refer to and for what investigations?

_____
_____

List your top 3 differentials and rationales for these.

_____
_____

HEADACHE CASE STUDY 1

John is a 44 year old prisoner who presents to your room complaining of headaches. These headaches have been present in previous years but now have become more intense. He describes the headaches as severe and present on both sides of his head. They tend to worsen during the course of the day. There is no associated visual disturbance or vomiting. He also complains of lack of appetite and trouble sleeping, with early morning waking. He has had eczema and irritable bowel syndrome diagnosed in the past, but these are not giving him problems at the moment. He is divorced with two children aged 10 and 12, who are cared for by his wife. His mother has recently died of a brain tumour. He smokes about 20 cigarettes per day and drinks 15 units of alcohol per week though he has been incarcerated for 6mnths now, hence he hasn't had any alcohol recently. He takes regular paracetamol or ibuprofen for his headaches.

EXAMINATION

John looks withdrawn. His pulse is 74/min and regular, blood pressure is 188/76 mmHg. Examination of the cardiovascular, respiratory and gastrointestinal system is normal. There are no abnormal neurological signs and fundoscopy is normal.

DISCUSS?

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HEADACHE CASE STUDY 1

James, a 24 year old, presents complaining of a severe headache. The headache started 24 hours previously and has rapidly become more intense. He describes the pain as generalized. He has vomited twice and appears to be developing drowsiness and confusion. He finds bright lights uncomfortable. There is no significant previous medical history or history of allergy. He smokes 10 cigarettes per day and drinks 24 units of alcohol per week. He is not taking any medication currently. He recently had a bit of a cold but has otherwise been well until this headache starts.

EXAMINATION

James looks flushed and unwell. His temperature is 39.2 and he has stiffness on passive flexion of his neck. There is no rash. His sinuses are not tender, and his eardrums appear normal. His pulse rate is 120/min and blood pressure is 98/74 mmHg. Examination of heart, chest and abdomen are normal. His level of consciousness is decreased but he is rousable to command and there are no focal neurological signs. His fundi are normal.

DISCUSS?

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HEADACHE CASE STUDY 3

Steve is a 46 year old who presented with a 15 year history of headaches. Headaches are bi-temporal, throbbing and last less than an hour. They are not associated with photophobia, phonophobia, nausea or vomiting. In the last 5 months, he has had a metallic taste in his mouth for roughly 20 minutes, followed by visual disturbances, that he describes as 'looking through water'. Associated symptoms include tingling of his left hand and left side of tongue, followed by numbness in his left leg. Headaches always follow after the numbness and taste episodes. After 30 minutes, all symptoms resolve. He has had these headaches 3 times/month for the last five months. Roughly one year ago, he had a single episode of slurred speech and tingling in his left hand and tongue, which resolved and has never recurred

EXAMINATION

Steve's appetite, weight and energy are normal, and he denies any cardiac, respiratory or GI problems. No visual deficits were found, though hearing in the left ear was less than on right. No weakness or changes in reflexes. No history or depression, anxiety, hypertension or trauma, but he does have a family history of migraines, heart disease and cancer.

DISCUSS?

_____

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HEADACHE CASE STUDY 4

Alan is a 33 year old man who presents with headaches that occur several times per month. He has had these headaches since he was 20 but has never sought treatment. The headache pain is sharp and severe, worse on the left side, causing burning, watery eyes, nausea and photophobia. He has a family history of hypertension and diabetes. He is married with two daughters. He denies alcohol and tobacco use. OTC analgesia is only mildly effective at controlling pain.

EXAMINATION

Alan denies visual disturbances, weight gain or loss, insomnia or any muscle aches and pains. He has no weakness or numbness and no history of head trauma. Observations are normal. Lung, heart, abdominal and neurological examinations are normal.

DISCUSS?

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MULTIPLE CHOICE QUESTIONS

To what drug does paroxysmal hemicrania respond well?

a. Amitriptyline
b. Topiramate
c. Verapamil
d. Indomethacin
e. Gabapentin

35-year-old female presents to the office with the complaint of right-sided facial pain. Medical history includes stabbing electric shocks exacerbated by eating, brushing her teeth and a brisk breeze across her face. The pain lasts a few seconds and rarely up to a couple of minutes. Physical examination shows normal facial sensation, normal bulk in the masseters bilaterally, and intact extra-ocular muscles.
Which is the most appropriate treatment in this patient?

A. Calcium Gluconate
B. Carbamazepine
C. Valproic acid
D. Clonazepam
E. Prednisone

48yr old females comes to the surgery cat 14h00 complaining of headache since 3am that day. She is complaining that the pain is unilateral and throbbing in nature. The patient says she was watching her sons school rehearsal not long before the onset of the headache. She says the rehearsal used strobe lighting for visual effects. She also mentions hallucinating light beams 'dancing in front of her' after the show.
Which of the following is the most likely diagnosis?

A. Migraine
B. SAH
C. Cluster Headache
D. Epilepsy
E. Tension headache

MULTIPLE CHOICE QUESTIONS

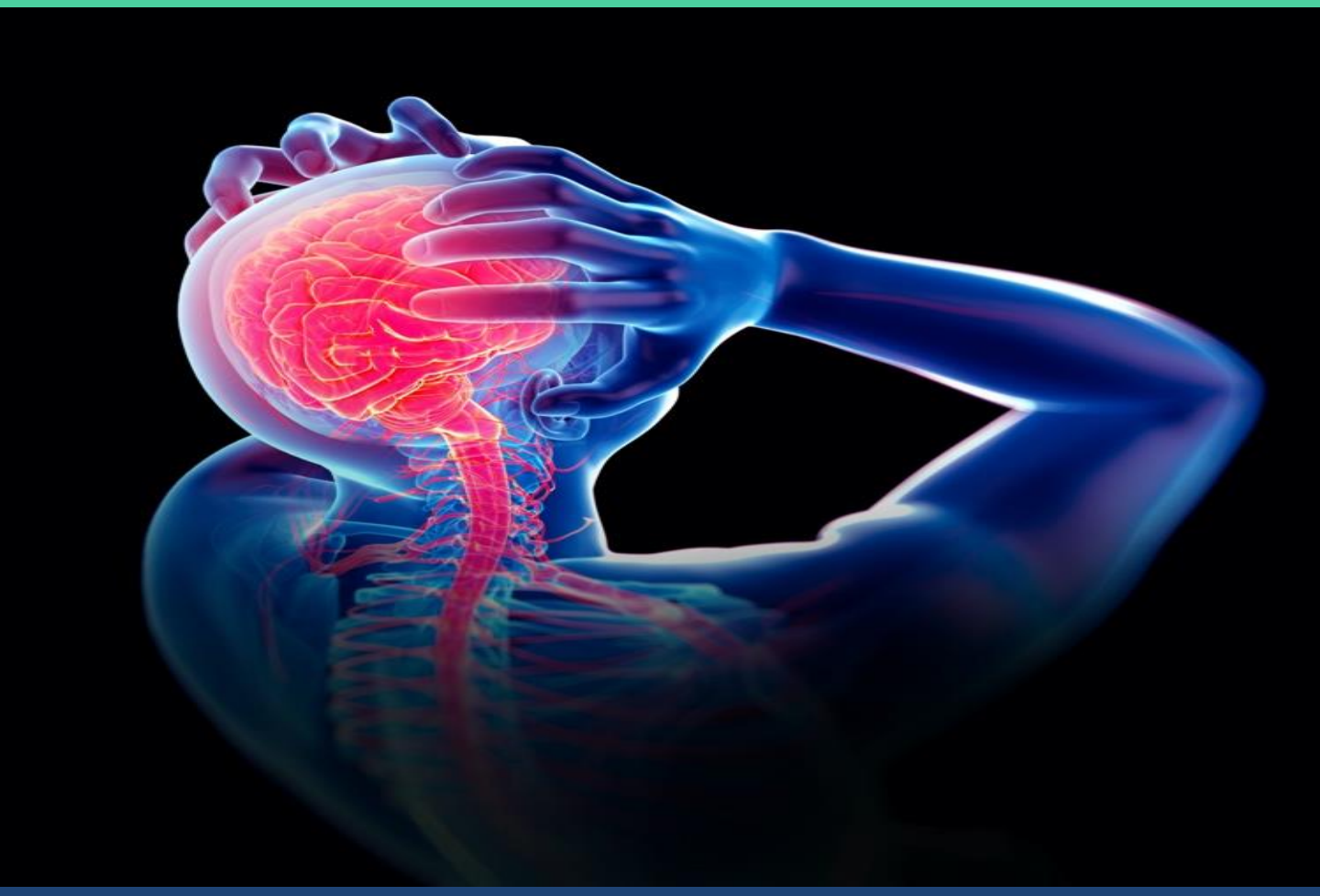
28yr old female presents with a severe headache that started 4hrs ago. Describes the headache as pulsating and localised to right eye. No relief with paracetamol and ibuprofen. **Which of the following drugs would you consider helping with her acute symptoms**

a. Metoclopramide
b. Naproxen
c. Ondansetron
d. Verapamil
e. sumatriptan

40-year-old man comes to the clinic because of a severe headache. He says his symptoms woke him from sleep 4 hours ago and consist of stabbing, burning pain located behind the right eye with nasal congestion. The same symptoms have around the same time of year for the past 5 years. Past medical history is significant for 30-pack-year smoking history. Physical examination reveals normal intraocular pressures bilaterally, normal visual acuity, and no fluorescein dye uptake on either cornea. His right eyelid is drooping with slight pupil constriction. **Which of the following is the most appropriate preventative measure for this patient?**

A. Verapamil
B. Propranolol
C. Sumatriptan
D. Ibuprofen
E. Paracetamol

BELMATT HEALTHCARE TRAINING



Contact Us

PHONE CALL
0207 692 8709

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Belmatt Healthcare Training

EMAIL US
info@belmatt.co.uk