Headaches

- Headaches are varied, management of the most common forms of headaches are listed under suggested GP management

Information Required

- Presence of red flags
- Clinical description including temporal profile
- Associated symptoms
- Medication / drug history
- Abnormalities on neurological examination
- If morning headache associated with symptoms of sleep apnoea consider referral to sleep physician

Investigations Required

- Copy of cerebral imaging report (if performed)

Fax Referrals to Neurology

Flinders Medical Centre Fax: 8204 4059

Red Flags

- **Thunderclap**, particularly if associated confusion, drowsiness, vomiting – refer to ED for exclusion of subarachnoid haemorrhage, venous sinus thrombosis, cervical artery dissection
- **Recent onset with confusion, drowsiness, neck stiffness or fever** – refer to ED to exclude meningitis, encephalitis, intracranial abscess, venous sinus thrombosis
- **Recent onset in patient over 50** – consider temporal arteritis – if clinical features suggestive start prednisolone 60mg daily and refer urgently. Other diagnostic considerations include brain tumour, subdural collection, sinusitis, cervical headache
- **Recent onset severe headache with cough, exertion or sexual activity** – refer to ED to exclude subarachnoid haemorrhage
- **Recent onset in young obese patient (particularly female)** – consider intracranial hypertension, ask regarding visual blurring or obscurations, intracranial noise and check for papilloedema
- **After head injury** – particularly if loss of consciousness, consider imaging or referral to ED depending on clinical severity
- **Headache which worsens with coughing, straining or bending over** – consider raised intracranial pressure. Check for papilloedema. Urgent imaging and referral as appropriate.
- **Superimposed new headache on background of chronic headache** – dramatic change in frequency or severity, change in character, unusual exacerbating factors, focal neurological symptoms

General Information to assist with referrals and the and Referral templates are available to download from the SALHN Outpatient Services website www.sahealth.sa.gov.au/SALHNoutpatients

Version	Date from	Date to	Amendment
2.0	September 2016	October 2018	Removal of RGH details
2.0	October 2019	October 2021	No changes
3.0	December 2022	December 2024	Fax number updated

Government of South Australia
SA Health

Suggested GP Management

Migraine

Acute Management

- ***First Line*** – High dose aspirin 600-900mg or Ibuprofen 200-400mg +/- metoclopramide or prochlorperazine
- ***Second Line*** – Triptans including sumatriptan, rizatriptan, eletriptan, naratriptan, zolmitriptam.
  If a lower dose is ineffective, than trial the higher dose where applicable (sumatriptan, eletriptan).
  If failure occurs to one, trial another.

Prevention

Consider if > 3 migraines/ month or if attacks are particularly disabling. Agents to consider include:

First Line:

- Amitriptyline 10mg nocte up to 100mg
- Propranolol 20mg bd up to 80mg bd
- Pizotifen 0.5 mg nocte up to 3mg nocte (abandon if no response to 1.5mg nocte)

Second Line

- Topiramate 25mg nocte up to 50mg bd

If failure occurs to one agent, try another and wean the first. If failure occurs to multiple agents refer to Neurology Department.

Menstrual migraine – if occurring predictably options include

- Naproxen 550mg bd started 48 hours before expected attack and continued beyond expected duration
- Oestradiol Gel 1.5 mg transdermally daily for 7 days started 48 hours before expected attack

Tension headache

Bland bilateral pressure discomfort with minimal associated features, often worse at the end of the day

Consider

- non pharmacological therapies such as massage, stretching and postural correction.
- Paracetamol or ibuprofen for acute relief.
- If frequent, amitriptyline starting at 10mg nocte.

AVOID CODEINE AND OTHER OPIATES

Medication Overuse

- The use of triptans, ergotamine, mixed analgesics or opiates for more than 10 days each month can transform a primary headache disorder such as migraine or less commonly tension headache to a chronic daily headache.
- **Prevention is the best treatment – AVOID OPIATES**
- Gradual reduction of analgesia over several weeks to months. May worsen headache before improvement is seen. Concurrent use of a preventative agent such as amitriptyline may make medication withdrawal easier.

Benign Exertional Headache Syndromes

- Long history of headache associated with specific activities such as sexual intercourse (at orgasm), on straining or coughing.
- Often responsive to indomethacin either regularly (25-50mg bd) or 1-2 hours prior to the precipitating activity such as sexual intercourse (25 – 50mg).
- Propranolol can be considered as a prophylactic agent

Cervical Headache

- Pathology of the first 3-4 cervical segments may cause an occipital headache which radiates to the frontal region or orbit.
- There may be associated resistance or limitation of neck movement, change in neck muscle tone or posture or abnormal neck muscle tenderness.
- Migraine and tension headache may be present and cervical imaging may or may not be helpful.
- Heat, a supportive neck pillow and neck physiotherapy may be helpful.

Clinical Resources

- Medlink Neurology – www.medlink.com