

Clinical Algorithms

Headache

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Headache, although a near universal experience, is a relatively uncommon reason for consultation in general practice. The consultation rate for migraine, for example, is said to be 12 per 1000 consultations, and it is estimated that the average general practitioner will see 28 patients on account of headache yearly.¹

Most headache is of the migrainous or tension type. Fry estimates that less than 1% of headaches presenting to a general practitioner reflect "major intracranial disease."² Despite its predominantly benign nature, headache may, however, be the presenting feature of potentially serious conditions such as cerebral tumour, meningitis, giant cell arteritis, and glaucoma. Cervical spondylosis, chronic sinusitis, and refractory errors probably cause headache less often than is commonly supposed.

Classification

A useful classification is that of the National Institute of Neurological Disease and Blindness 1962.³ This is summarised below.

- (1) Vascular headache of migraine type:
 - A Classic migraine,
 - B Common migraine,
 - C Cluster headache,
 - D Hemiplegic and ophthalmoplegic migraine,
 - E "Lower half" headache.
- (2) Muscle contraction headache.
- (3) Combined headache: vascular and muscle contraction.
- (4) Headache of nasal vasomotor reaction.
- (5) Headache of delusional, conversional, or hypochondriacal states.
- (6) Non-migrainous vascular headaches:
 - A Systemic infections,
 - B Miscellaneous disorders.
- (7) Traction headache:
 - A Primary or metastatic tumours of meninges, vessels, or brain,
 - B Haematomas,
 - C Abscesses,
 - D Postlumbar puncture headache,
 - E Pseudotumour cerebri.

- (8) Headache due to overt cranial inflammation:
 - A Intracranial,
 - B Extracranial (arteritis, cellulitis).
- (9) Headache due to disease of ocular structures.
- (10) Headache due to disease of aural structures.
- (11) Headache due to disease of nasal and sinus structures.
- (12) Headache due to disease of dental structures.
- (13) Headache due to disease of other cranial and neck structures.
- (14) Cranial neuritides (trauma, new growth, inflammation).
- (15) Cranial neuralgias.

Diagnosis

History—Try to discover why the patient is presenting now. In many cases, particularly of acute onset headache, the reason will be clear. In a considerable proportion of cases of longstanding headache the consultation will have been precipitated by other factors. In particular, look for any underlying anxiety or depression. Attempt to elicit obvious pointers to specific causes (detailed in the classification and algorithm). From the history it is often not possible to differentiate serious from more benign causes. Features such as intensity, response to head movement and to vasoactive drugs, and the presence of a tender cervical spine with diminished movement do not have discriminating value. There are, however, certain uncommon alerting features, which again do not clearly discriminate but which should give rise to suspicion of in particular an expanding intracranial lesion. These are: (a) sleep disturbance, (b) paroxysmal headache, (c) cough headache.⁴

Examination—One cannot be dogmatic about the approach to examination in general practice. Nevertheless, it is reasonable to measure the blood pressure in all cases. In older patients examination of the superficial temporal arteries and of the intraocular tension would be appropriate. Examination will, on the whole, be guided by the history.

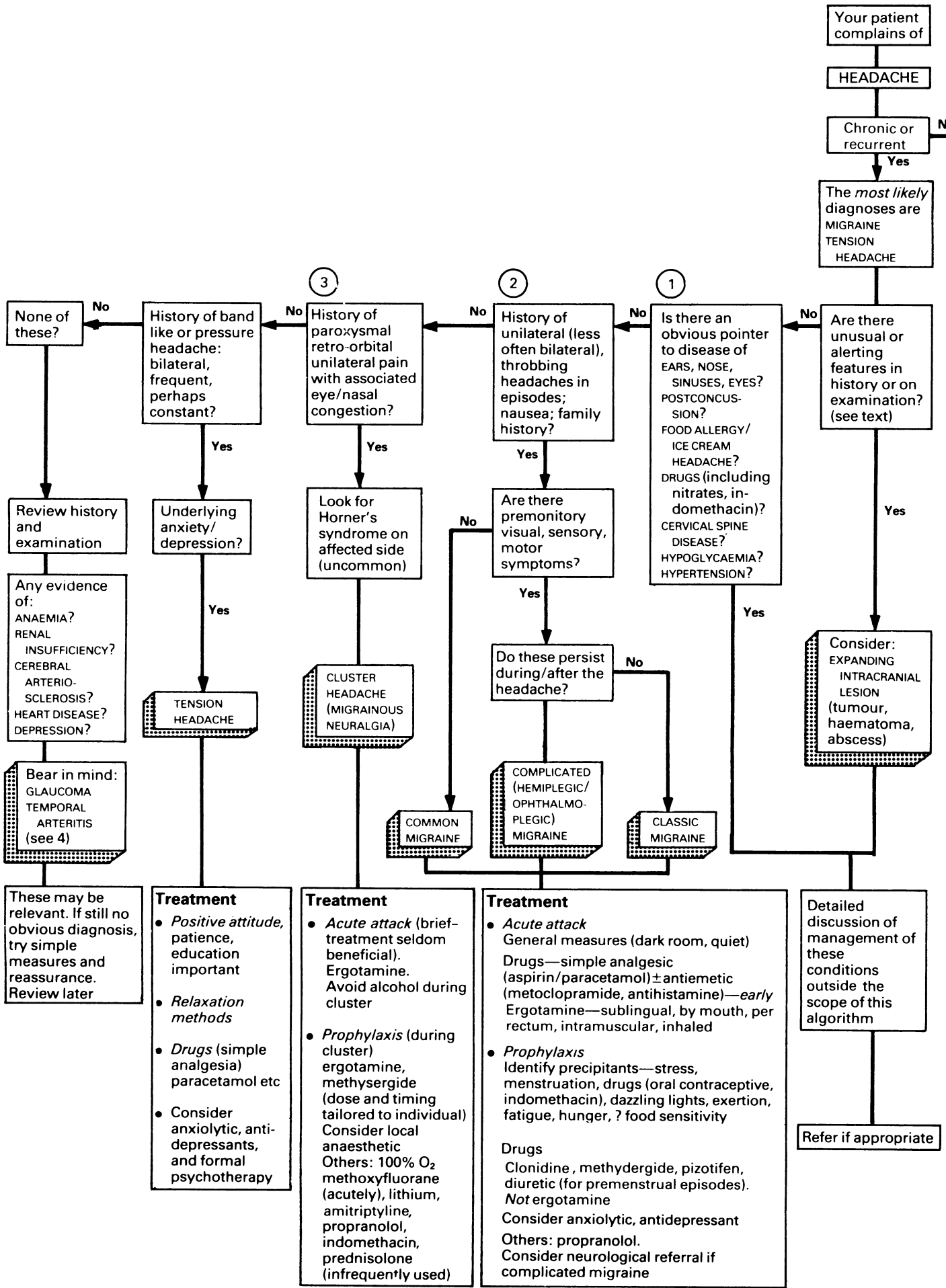
Investigations—There is no indication for routine investigation, other than the erythrocyte sedimentation rate in the older patient.

¹ Royal College of General Practitioners/Office of Population Censuses and Surveys 1974. *Morbidity statistics from general practice: second national study 1970-71*. London: HMSO, 1974. Studies on Medical and Population Subjects No 26.

² Fry J. *Common diseases, their nature, incidence and care*. 2nd ed. Lancaster: MTP Press Ltd, 1979.

³ Vinken PJ, Bruyn GW. *Handbook of clinical neurology 5: headaches and cranial neuralgias*. Amsterdam: North Holland Publishing Company, 1968.

⁴ Raskin NH, Appenzeller O. *Headache*. Philadelphia, WB Saunders, 1980. (Major problems in internal medicine; vol 19.)



These may be relevant. If still no obvious diagnosis, try simple measures and reassurance. Review later

Treatment

- *Positive attitude, patience, education important*
- *Relaxation methods*
- *Drugs (simple analgesia) paracetamol etc*
- *Consider anxiolytic, anti-depressants, and formal psychotherapy*

Treatment

- *Acute attack (brief-treatment seldom beneficial). Ergotamine. Avoid alcohol during cluster*
- *Prophylaxis (during cluster) ergotamine, methysergide (dose and timing tailored to individual) Consider local anaesthetic Others: 100% O₂ methoxyfluorane (acutely), lithium, amitriptyline, propranolol, indomethacin, prednisolone (infrequently used)*

Treatment

- *Acute attack* General measures (dark room, quiet) Drugs—simple analgesic (aspirin/paracetamol) ± antiemetic (metoclopramide, antihistamine)—*early* Ergotamine—sublingual, by mouth, per rectum, intramuscular, inhaled
- *Prophylaxis* Identify precipitants—stress, menstruation, drugs (oral contraceptive, indomethacin), dazzling lights, exertion, fatigue, hunger, ? food sensitivity

Drugs
Clonidine, methyergide, pizotifen, diuretic (for premenstrual episodes).
Not ergotamine
Consider anxiolytic, antidepressant

Others: propranolol.
Consider neurological referral if complicated migraine

Detailed discussion of management of these conditions outside the scope of this algorithm

Refer if appropriate

Headache

