GROUP TUTORIAL ON HEADACHE

This was a joint tutorial with 3 GPRs on headache in 1.5 hours on 7.10.13

They identified headache as being a heartsink presenting complaint. They scored it 7,7,8 on a heartsink scale out of 10!

When we explored the reasons for this they listed:
Having to do a dreaded (and often pointless) CNS exam-however CSA would expect this.
Patients being stressed, anxious and depressed and this taking time to explore.
Being confused by the classification of headache-eg what's a “chronic” migraine?
Feeling unable to offer very much other than more painkillers which could often do harm.
Being nervous about missing a serious cause eg brain tumour.

We reviewed the nice guidance on headache 2012 and talked generally.

<http://www.nice.org.uk/nicemedia/live/13901/60853/60853.pdf>

We shared that history was everything with headache and the examination rarely added anything. However, a basic exam with fundoscopy, Bp and checking temporal arteries was reasonable.
The classification was basically tension type, migraine or cluster headache for primary headache (remember TA, sinusitis as causes of secondary headache) and if present for >15 days per month was "chronic" rather than episodic.

Medication overuse is a big problem in chronic headache and meds should be limited to no more than 10 days in 30.
The advice is to go cold turkey and stop meds quickly for at least 1 month. This can be st the same time as treatment for the underlying cause of primary headache eg migraine prophylaxic.

In migraine, lifestyle advice can be helpful and patients find it useful to discuss: small regular meals to avoid dropping blood sugars, 6-8 hrs sleep per night, watching for foods eg chocolate or cheese as triggers and taking some regular exercise. A headache diary is helpful.
Acute treatment in the form of an anti emetic eg domperidone followed by soluble aspirin in coke works well. A minority of patients (3/10) need a triptran (NICE recommends concurrent use of a triptan and nsaid).

Prophylaxis is under prescribed and propranolol for example works well at reducing headache frequency( min 6 month course). Topirimate is also advocated. A 10 session course of acupuncture also works well for tension type headache and migraine prophylaxis.

Re cluster headache the features are typical and acute treatments eg nasal triptans or high flow oxygen work well. However these patients often require preventative treatments as well eg verapamil (steroids or Greater occipital nerve blocks). OUCH have a good website for cluster headache:

 <http://www.ouchuk.org/html/>

In terms of missing serious causes of headache that was unlikely in GP provided that the onset of headache was not thunderclap, there were no features of raised icp and no focal neurology. In fact with a good migraine history the chances of an undiagnosed brain tumour are no more than background population risk.

We performed a role play modelling a chronic migraine consultation.

By the end the heartsink scores were 5,5,6 (from 7,7,8)!!!

AK 10/13