Red Flags in headache presentation

Red Flags in headache presentation include:

Age

- Over 50 years at onset of new headache
- Under 10 years at onset

Characteristics

- First, worst or different from usual headache
- Progressive headache (over weeks)
- Persistent headache precipitated by Valsalva manoeuvre (cough, sneeze, bending or exertion)
- Thunderclap headache (explosive onset)

Additional features

- Atypical or prolonged aura (>1 hour)
- Aura occurring for the first time in woman on combined oral contraceptive
- New onset headache in a patient with a history of cancer or HIV
- Concurrent systemic illness
- Neurological signs
- Seizures
- Symptoms/signs of Giant Cell Arteritis (e.g. jaw claudication)

Diagnostic criteria for migraine without aura

A	At least 5 attacks fulfilling criteria B–D
B	Headache attacks lasting 4–72 hours* (untreated or unsuccessfully treated)
C	Headache has at least two of the following characteristics: 1. Unilateral location* 2. Pulsating quality (i.e. varying with the heartbeat) 3. Moderate or severe pain intensity 4. Aggravation by or causing avoidance of routine physical activity (e.g. walking or climbing stairs)
D	During headache at least one of the following: 1. Nausea and/or vomiting* 2. Photophobia and phonophobia
E	Not attributed to another disorder (history and examination do not suggest a secondary headache disorder or, if they do, it is ruled out by appropriate investigations or headache attacks do not occur for the first time in close temporal relation to the other disorder).

***In children**, attacks may be shorter-lasting, headache is more commonly bilateral, and gastrointestinal disturbance is more prominent.

Medications for migraine prophylaxis in primary care

	Evidence	Additional benefits	Risks	Dose	Comorbidities to consider
Beta blockers Good evidence base	RCTs for metoprolol, propanolol, nadolol and atenolol		Cold extremities, reduced exercise tolerance, dizziness	Metoprolol 50–100 mg BD Propanolol LA 80 mg daily to 160 mg BD	Asthma, heart failure, peripheral vascular disease, depression
Tricyclics Adequate evidence base	Evidence for effectiveness from small RCTs of amitriptyline	Helps with co-existent tension headache, other pain conditions, disturbed sleep and depression. Some evidence of synergy with beta blockers	Sedation, dry mouth, dizziness, nausea Less side effects with nortriptyline	10–150 mg at night	Concurrent use of other anti-cholinergic medications
Sodium valproate Good evidence base	RCTs		Nausea, weight gain, alopecia, spontaneous bruising, liver dysfunction	300–1000 mg BD	Contra-indicated in pregnancy

RCT = Randomised Controlled Trial

Management of migraine during pregnancy

Paracetamol	Can be used throughout pregnancy and breast-feeding
NSAIDs	Avoid in the third trimester to avoid fetal renal damage and patent ductus. In the first and second trimester short acting NSAIDs, such as ibuprofen, are preferred
Metoclopramide	Unlikely to cause harm through pregnancy and breast-feeding
Triptans and ergotamine	Contraindicated However, women who have taken sumatriptan inadvertently in pregnancy can be reassured current evidence suggests they are at no greater risk of birth defects than the general population
Propanolol	Beta blocker with best evidence of safety during pregnancy
Amitriptyline	Lowest effective dose may be used