Information about primary headache

You have been diagnosed with a primary headache

It is natural for people with severe headaches to be concerned that they have a serious brain abnormality. However, research into such headaches shows they are almost never caused by serious problems. We now recognise that such headaches are from an overly active pain system, within a structurally normal brain. Most headaches affect the scalp, face and neck, rather than being restricted to the scalp and the pain can be dull, sharp, pressure like, etc.

There are different types of primary headaches, which include migraine, tension headaches, cluster headaches and neuralgia.

Migraine

Migraine varies a lot between people. It causes a range of symptoms including headaches, so your migraines may be different to those experienced by other people. Migraine has two patterns:

1. Episodic – episodes of severe headaches, either one sided or all over the head, associated with symptoms such as nausea and vomiting, sensitivity to light, noise or movement. Episodic migraines can last from a few hours to a full week but then go away completely leaving you headache free and feeling well until the next episode.

   Episodic migraines can be with aura or without aura. Aura is a neurological symptom causing visual disturbance or pins and needles of the face, arm or leg. Aura develops over several minutes but goes away within an hour and occurs in only 20% of migraine patients.

2. Chronic migraine – in this pattern, you will notice a dull “hangover” type of pain more than half of the days in each month, with regular severe headaches on top. This can go on for months.

   Most patients with episodic or chronic migraine will describe pain behind the eyes, face, scalp, back of the head and neck down to the shoulder. Some patients are tired, lightheaded and dizzy, others may have problems with balance, attention span, concentration and memory, and may experience pins and needles, or blurring of vision. This can make it difficult to function at home and at work.

Treatment

1. Trigger factors – the following are well recognised triggers for migraine:

- Stress
- Tiredness
- Lack of sleep
- Dehydration
- Missing meals

• Regular intake of alcohol and caffeine
• Changes in hormone levels (in women)

Some patients find that certain foods appear to be associated with the onset of their migraines, but it is quite rare for specific foods to trigger the attack. Tiredness, yawning, hunger, thirst, passing more urine, or feeling more sensitive to noise or light can all be present in the build up to a severe migraine. Avoiding your trigger factors can help towards getting better control of your migraines.

You are strongly advised to maintain a migraine diary to assess your headache pattern and response to treatment. Please ask for The Walton Centre headache diary.

2. Medication - Pain control

Pain killers are usually helpful if you have episodic (and relatively infrequent) migraines. These include:

- "Triptans" – eg sumatriptan, rizatriptan, zolmitriptan
- Anti-inflammatories (eg aspirin, ibuprofen, naproxen) in combination with an anti-sickness medicine (eg metoclopramide, cyclizine)

These can be used singly or in combination. These should be used as soon as an attack of migraine headache starts so that they have the best chance of working effectively.
However, using any of these pain killers more than 10-15 times per month risks causing "medication overuse headaches". These are dull, "hangoverlike", persistent headaches that continue after the severe attacks are over.

Strong pain killers (ie those containing codeine, morphine or tramadol) should be avoided in migraine as they frequently cause "medication overuse headaches" and can worsen the condition in the long run

Preventative treatments

If episodic migraine attacks occur regularly, more than once or twice a week, or if you have chronic migraine, a preventative medicine should be considered, and you should discuss this with your GP. These will only work if you cut down on the use of regular pain killers and caffeine.

Preventative medicines include propranolol, amitriptyline, nortriptyline, topiramate, sodium valproate and candesartan.

Sodium valproate and topiramate should not be prescribed to women of child-bearing age due to the risk of it causing developmental defects in babies. Topiramate can interact with the oral contraceptive pill, can also affect the unborn child and cause lowering of mood. Women are advised to be on an appropriate contraceptive and not to get pregnant while on any of the preventatives.

Many of these medicines are used for other medical conditions as well as headaches. Preventative medicines should be taken regularly, starting at a small dose and gradually increasing as recommended by your doctor. The effect will become obvious only after being on a reasonable dose for up to three months. If it works, such medication will usually be taken for a year before it is slowly withdrawn to see if it is still needed.

You may need to try several different preventatives before finding the one that works for you. Painkillers and caffeine should be stopped for preventatives to work efficiently. If patients with frequent episodic migraines or chronic migraine do not respond to adequate trials of two or

more preventatives, they may require referral to a neurologist for further treatment. Remember to take your completed migraine diaries with you when you go for the consultation.

Websites with useful information include:
www.migraine.org.uk
www.migrainetrust.org
www.brainandspine.org.uk

Tension headache

Tension headache feels like a band or tightness across the forehead and scalp that is never severe and is not associated nausea or sensitivity to light. If your headache is significant and affecting your capacity to function it is most likely migraine rather than tension headache. For intermittent headaches, simple pain control can help (but only if used less than 10-15 times per month).

If headaches occur regularly or continuously, a preventative medicine (nortriptyline or propranolol) may be beneficial.

Cluster headache

Cluster headaches are not migraines. They affect men more than women. The pain is very severe, strictly one sided and attacks can regularly wake up a person from sleep. This is accompanied by symptoms including:

- Redness and watering from one eye
- A blocked nose on the same side
- Intense restlessness and agitation – which results in patients rocking back and forth or pacing up and down (as opposed to patients with migraines who prefer to lie down or sit still and keep away from light and noise).

The attacks tend to cluster together over weeks or months although pain free intervals can also last weeks or months.

Treatment

1. Reduce trigger factors – these include alcohol and warm weather. You are advised to limit trigger factors where possible. Smokers are advised to stop smoking
2. Pain control – standard pain killers do not work for cluster headaches. The effective ones (listed below) must be taken at the beginning of an attack:
    - Sumatriptan injection or nasal spray
    - High flow oxygen - prescribed by your GP or a neurologist
    - A short course of corticosteroids (prednisolone) over 10-14 days can stop attacks until preventative treatment starts working.

Preventative treatment

All patients should be prescribed a preventative treatment. Verapamil is one of the most effective. Patients with cluster headache should be referred to a neurologist.
Websites with useful information: www.ouchuk.org

Neuralgia

Trigeminal neuralgia usually affects one side of the cheek or jaw area of the face. It causes intermittent, sharp shooting pains (similar to an electric shock) that can be triggered by touching the face, chewing, etc.

Certain viruses (e.g. the one that causes chicken pox and shingles) can cause a painful blistery rash and subsequent neuralgia. Often, trigeminal neuralgia happens spontaneously. Constant pain all over the face is NOT neuralgia.

Treatment

Medicines such as carbamazepine, oxcarbazepine, gabapentin, pregabalin or amitriptyline – alone or in combination – are useful for both acute pain control and for preventing neuralgia. These medicines must be taken regularly and the dose gradually increased until the attacks stops.

If attacks do not stop despite an adequate trial of these treatments, referral to a neurologist or pain specialist might be necessary.

Websites with useful information: www.tna.org.uk

Consent

Although you consent for this treatment, you may at any time after that withdraw such consent. Please discuss this with your medical team.

Important information

The information in this leaflet is for guidance purposes only and is not provided to replace professional clinical advice from a qualified practitioner.

Your comments

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Hand hygiene

The Trust is committed to maintaining a clean, safe environment. Hand hygiene is very important in controlling infection. Alcohol gel is widely available at the patient bedside for staff use and at the entrance of each clinical area for visitors to clean their hands before and after entering.

Other formats

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After reading this information are there any questions you would like to ask? Please list below and ask your nurse or doctor.

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Reference

The directorate group that has agreed this patient information leaflet:
Neurology Clinical Governance Group

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