

LRI Emergency Department

Acute headache

Use in adults with a main presenting complaint of headache <2 weeks

DO NOT use if

- GCS <15
- T >37.9°C
- WCC >12
- New cognitive dysfunction
- New neurological deficits
- Haemodynamic instability
- Pregnancy at 20 weeks gestation or over, with known pre-eclampsia or ED BP >139/89

Disclaimer:
This is a clinical template; clinicians should always use judgment when managing individual patients

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Patient details

Full name

DoB

Unit number

(use sticker if available)

① SAH high-risk indicators?

Yes, as at least one of the below

- TLOC (transient loss of consciousness)
- Neck stiffness (defined as inability to touch chin to chest or, if supine, raise head 8cm off trolley or bed)
- Diplopia
- Seizure
- Previous SAH
- Family history of SAH
- Known unruptured cerebral aneurysm
- History of intracranial aneurysm in at least one 1st-degree relative
- Autosomal dominant polycystic kidney disease
- Ehlers-Danlos syndrome type IV
- Fibromuscular dysplasia
- Pseudoxanthoma elasticum

No, as none of the above

② Other SAH investigation criteria?

Yes, as at least one of the below

- Aged 40 years or more
- Therapeutic anticoagulation
- Thunderclap headache (i.e. peaking within 5min)
- C/O neck pain or stiffness
- Headache onset during exertion
- Known brain tumour

No, as none of the above

③ Other imaging indications?

Yes - one or more of the below

Suspected intracranial bleed

- Suspected intracranial bleed
- Therapeutic anticoagulation
- Platelets <100
- Known coagulopathy
- Re-attending ED after recent head injury (unless CT already done and normal)

Suspected intracranial malignancy

- History of brain tumour
- History of malignancy known to metastasise to the brain; i.e. Breast
- Lung
- Kidney
- Thyroid
- Melanoma
- Hodgkin's lymphoma
- History of malignancy **AND** aged <20
- Change in personality
- Vomiting without obvious cause

Suspected raised intracranial pressure

- Ventriculoperitoneal shunt

No - none of the above

④ Giant cell arteritis suspected?

NB: Applies only if patient aged >50 with new headache and raised CRP and/or PV

Yes, as at least one of the below

- Scalp tenderness
- Transient visual symptoms
- Unexplained facial pain
- Jaw or tongue claudication
- Abnormal temporal artery (i.e. tender, beaded, enlarged or with absent pulse)

No, as none of the above

⑤ Neurology follow-up needed?

Yes, as at least one of the below

Same-day neurology opinion

- Orthostatic headache (= pain when upright that disappears rapidly on lying down)
- 1st bout of cluster headache

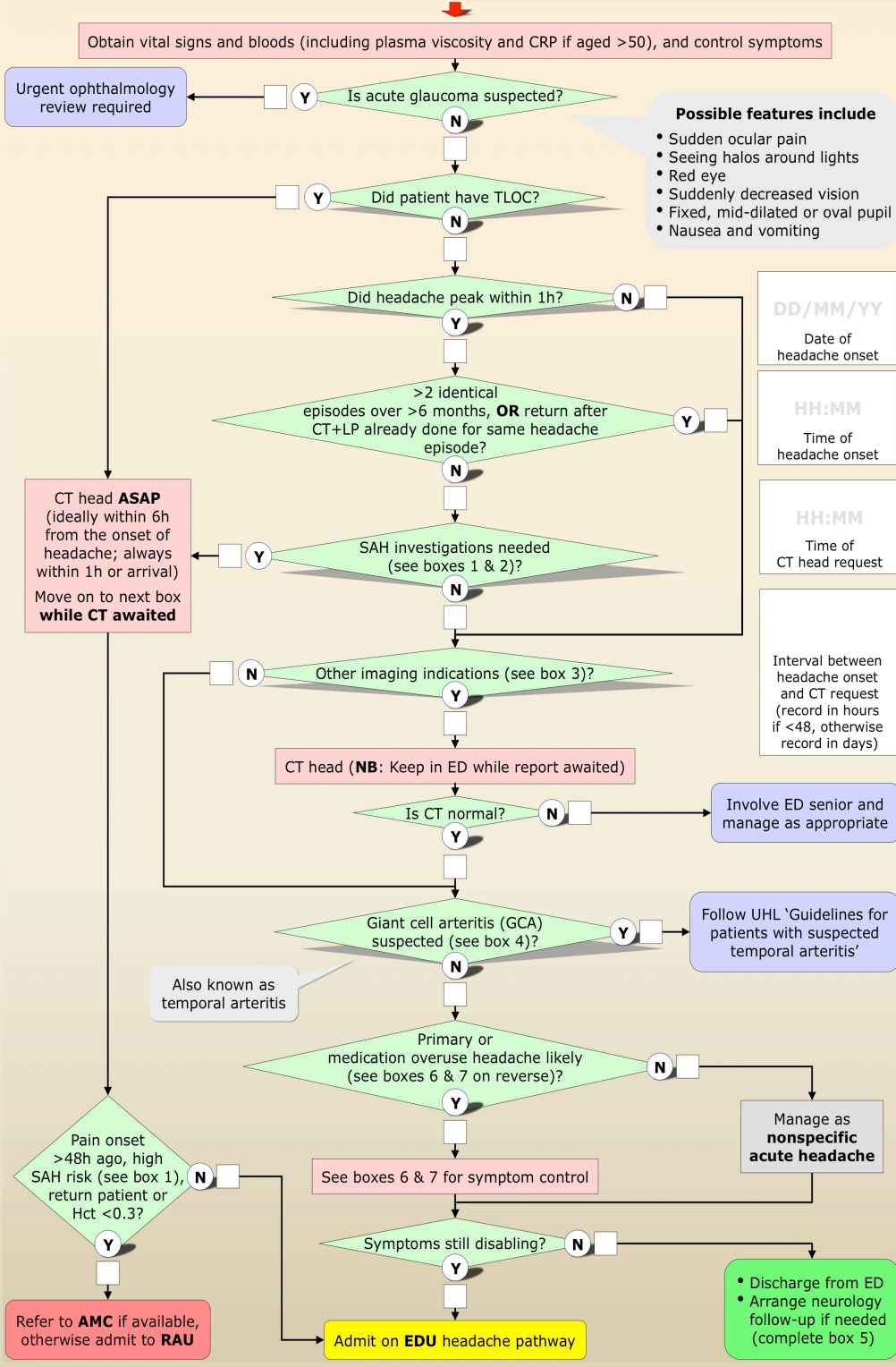
Early neurology OPD follow-up

- Pregnant patient requiring **either** treatment for cluster headache or prophylaxis for migraine
- Patient on immunosuppressant drugs
- HIV patient (**NB**: refer to **IDU** instead)

Neurology OPD follow-up for GP to consider

- Pain triggered by cough, Valsalva or sneeze
- Substantial change in characteristics of a patient's usual headache

No, as none of the above



Patient managed by

Print name

Signature

Role

⑥ Could patient have medication overuse headache?

Consider this diagnosis if symptoms developed or worsened while patient was taking (tick as applicable):

Triptans, opioids, ergots or combination analgesic drugs (e.g. co-codamol) on 10 days a month or more since at least 3 months

Paracetamol, aspirin or an NSAID (in any combination) on 15 days a month or more since at least 3 months

Control pain with PO paracetamol **AND** aspirin 900mg or another NSAID (if not contraindicated). **DO NOT** give any of the overused drugs.

⑦ Could patient have a primary headaches syndrome?

Consider the clinical features below and tick a diagnosis (if applicable)

NB: Primary headaches may be felt in head, face or neck. A certain minimum number of characteristic episodes, e.g. >9 for tension-type headache or >4 for migraine without aura, is required to confirm the diagnosis.

Medication overuse headache may make it difficult to diagnose any underlying primary headache.

Location of pain	Bilateral		Unilateral or bilateral			Unilateral (around or above the eye and along the side of the head / face)	
Quality	Non-pulsating (pressing / tightening)		Pulsating (throbbing or banging in young people aged 12-17 years)			Variable (can be sharp, boring, burning, throbbing or tightening)	
Intensity	Mild or moderate		Moderate or severe			Severe or very severe	
Duration	30 minutes – continuous		Adults: 4–72 hours Aged 12-17: 1–72 hours			15 – 180 minutes	
Effect on activities	Not aggravated by routine activities of daily living		Aggravated by, or causes avoidance of, routine activities of daily living			Restlessness or agitation	
Additional symptoms	None		Unusual sensitivity to light and / or sound or nausea and / or vomiting Aura symptoms can occur with or without headache and: <ul style="list-style-type: none"> • are fully reversible • develop over at least 5min • last 5 – 60min Typical aura symptoms include <ul style="list-style-type: none"> • visual symptoms such as flickering lights, spots or lines and / or partial loss of vision • sensory symptoms such as numbness and / or pins and needles • speech disturbance Atypical aura symptoms include <ul style="list-style-type: none"> • motor weakness • double vision • visual symptoms affecting only one eye • poor balance • decreased level of consciousness 			On the same side as the headache: <ul style="list-style-type: none"> • red and / or watery eye • nasal congestion and / or runny nose • swollen eyelid • forehead and facial sweating • constricted pupil and / or drooping eyelid 	
Frequency	<15 days per month	≥15 days per month for >3 months	≥15 days per month for >3 months	<15 days per month	predominantly between 2 days before and 3 days after the start of period in at least 2 out of 3 consecutive cycles	during a bout, 1 every other day up to 8 per day with remission between bouts >1 month	during a bout, 1 every other day up to 8 per day with a continuous remission between bouts <1 month in a 12-month period
Diagnosis (tick as applicable)	Episodic tension-type headache <input type="checkbox"/>	Chronic tension-type headache <input type="checkbox"/>	Chronic migraine (+/- aura) <input type="checkbox"/>	Episodic migraine (+/- aura) <input type="checkbox"/>	Menstrual migraine (+/- aura) <input type="checkbox"/>	Episodic cluster headache <input type="checkbox"/>	Chronic cluster headache <input type="checkbox"/>
		Overlap is common. If in doubt, treat as migraine.					
Control of acute symptoms	Paracetamol AND aspirin 900mg or another NSAID PO (if not contraindicated). DO NOT give opioids.		Prochlorperazine 12.5mg IM or metoclopramide 10mg IV / IM (even if patient not feeling nauseous) AND paracetamol AND aspirin 900mg or another NSAID (if not contraindicated) AND sumatriptan 100mg PO (NB: if aged <18: zolmitriptan 5mg intranasally instead). DO NOT give opioids.			Same as for other migraine types, but GP may consider frovatriptan or zolmitriptan (both 2.5mg PO) if other triptans not effective	
					Oxygen 12-15L/min via non-rebreathing mask with reservoir bag AND zolmitriptan 5mg intranasally. GP may consider sumatriptan 6mg SC if the above not effective. DO NOT give opioids, paracetamol, aspirin or other NSAIDs, or oral triptans.		

NB: These patients require referral to stroke team and neuroimaging unless the diagnosis has been firmly established previously