Headaches in A&E

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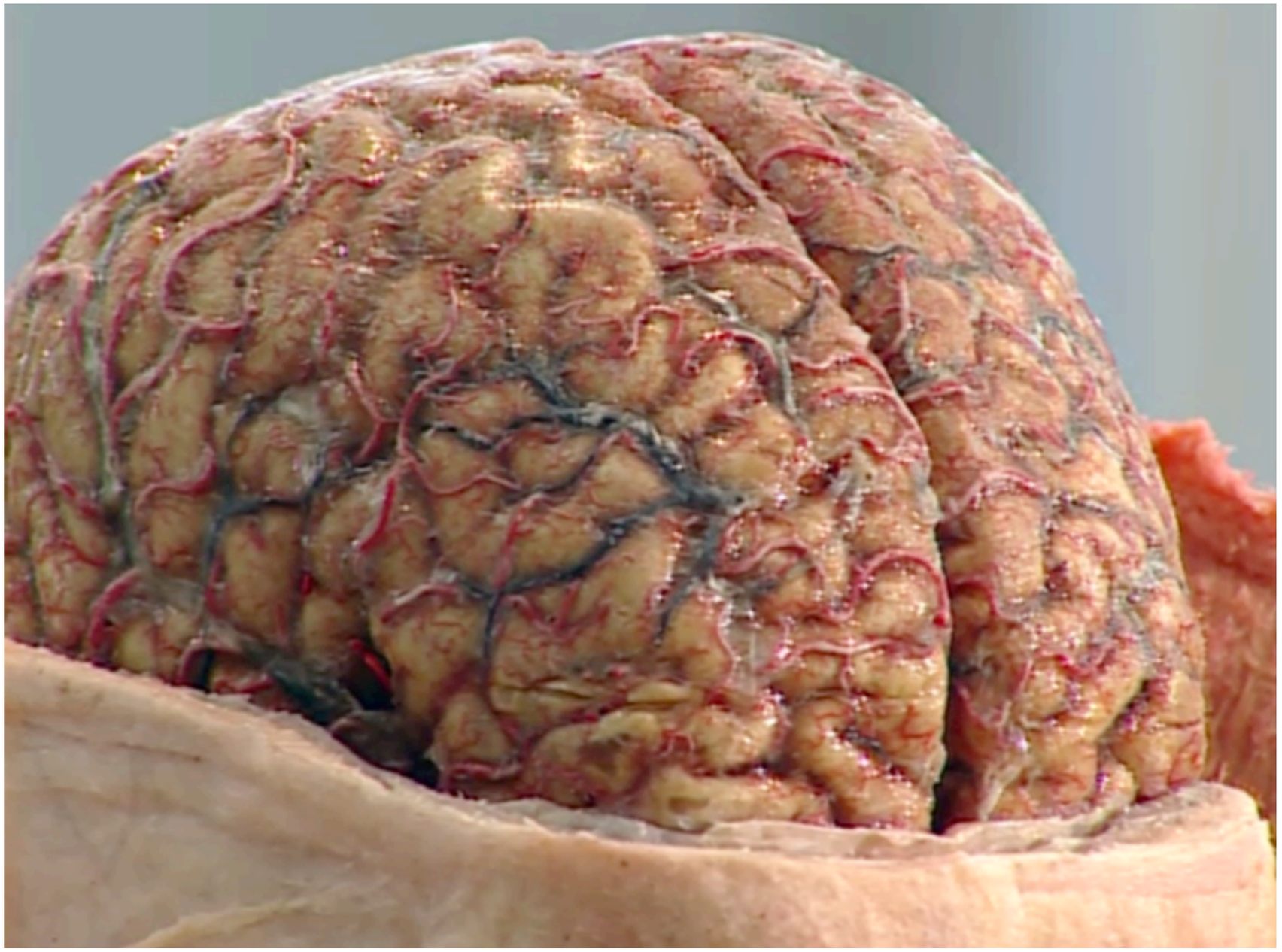
Contents

Introduction

- VERY Common, 0.5-4% A&E pts
- Usually benign but can be life threatening (10-15%)
- Important not to miss serious diagnoses
- Large differential list!
- Public worried about ‘avin brain tuma’



Your Approach?

Approach

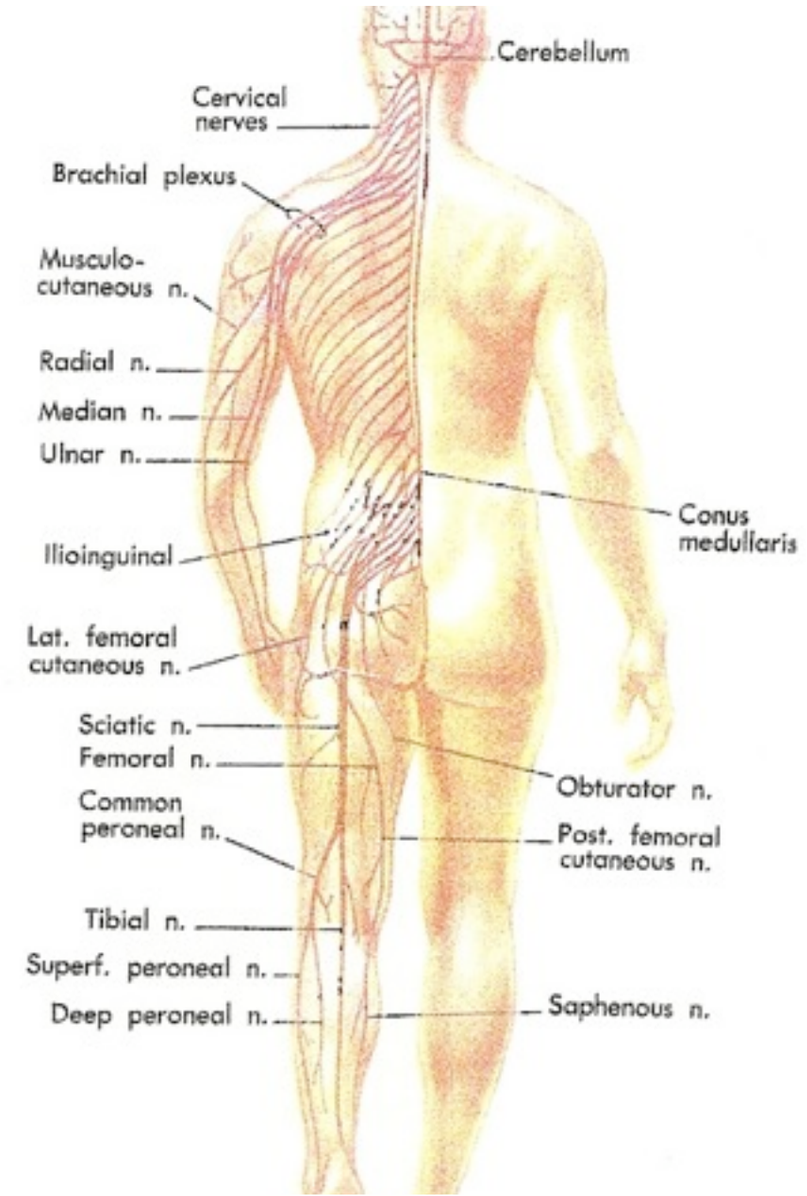
- Detailed History; details of speed onset, position, timing, associations, neurology. Previous malignancy, fevers etc
- CNS Systems Hx
- Drug history
- Often above will make it clear (eg reduced GCS, headache, fever, neck stiff, vomiting)
- Check specifically for worrying 'flags'-see next flag
- Try and fit to known patterns, if ?primary headache

FLAGS

- Sudden onset (SAH) and maximal
- Headache unlike any previous
- Known malignancy/ immunocompromised
- VP shunt
- Headache on exertion
- New onset >50 years
- Worse in morning/bending
- Fever & headache/neck stiffness
- Recent head and neck instrumentation/infection
- Neuro deficits
- Altered GCS
- Unilateral visual reduction/eye pain
- PREGNANCY (eclampsia)
- Other in family/am (CO)

Examination

- Generally well?/fever.
- Routine observations
- Rashes
- Complete Neuro exam
- Pupils & Fundoscopy and visual acuity
- Look for trauma (eg elder abuse), check ears and sinuses
- Palpate temporal arteries
- Neck stiffness.



Secondary headaches

- Head injury
- Drugs; s/e, misuse, analgesia withdrawal
- Craniofacial (TMJ, ear, teeth, neck, eye-glaucoma etc etc)
- Vascular; SAH, AVM
- Infection (meningitis, abscess, encephalitis)
- Metabolic (hypoxia, hypercapnia, CO, ↑BM)
- ICP (post LP, tumour, bening IC hypertension)
- Neuralgias (trigeminal, occipital)

Primary headaches

- Migraine
- Cluster
- Tension
- Misc (cough/sex etc)

Migraines

- Aura, scintillating scotoma
- Recurring, Gradual onset
- Pulsating, unilateral
- Mod-Severe
- 4-72 hours
- Nausea and vomiting
- Rarer; hemiplegic, basilar, ophthalmic, acephalgic

- Triggers: in 50% =CHOCOLATE (Cheese, OCP, Caffiene, alcohol, anxiety, travel, exercise). also fatigue, menstruation etc
- Photophobia, phonophobia
- Regular analgesia/NSAIDS/ metoclopramide/ergotamine 1mg po/sumatriptan 6mg sc
  (not IHD, hemiplegic, hypertensives, or ergotamine <24hrs)

Tension

- Commonest
- Recurring
- Bilateral/band like, dramatic
- Non-pulsatile
- Mild-Mod
- 4-13hours
- usually neck muscle spasm
- regular analgesia, GP follow up

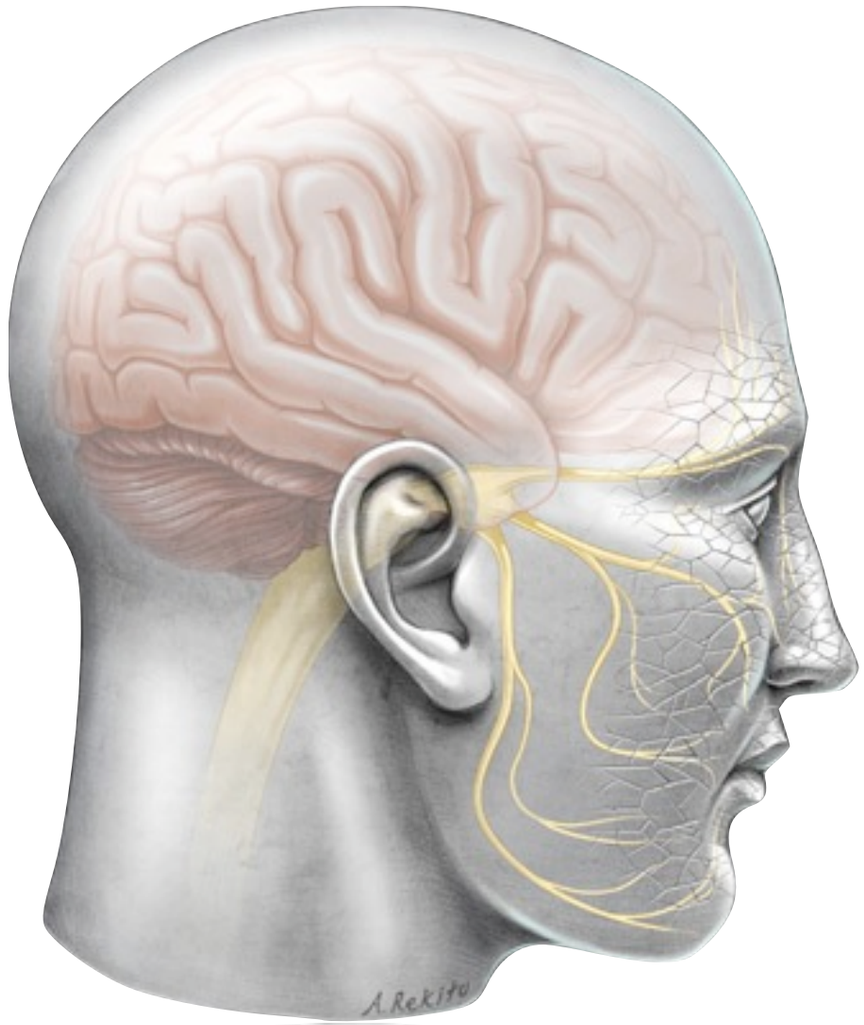
Cluster

- ♂:♀ 5:1
- Unilateral behind eye, night
- Lacrimation/red eye/Ptosis
- Rhinorrhoea
- Clusters 8/d over days/weeks then gone for months/yrs. Last 15-160mins
- Severe ++

- 100% 0_2 15 mins/ Paraceetamol/NSAIDs/ (Ergotamine or Sumatriptan 6mg at onset sc after consultation)

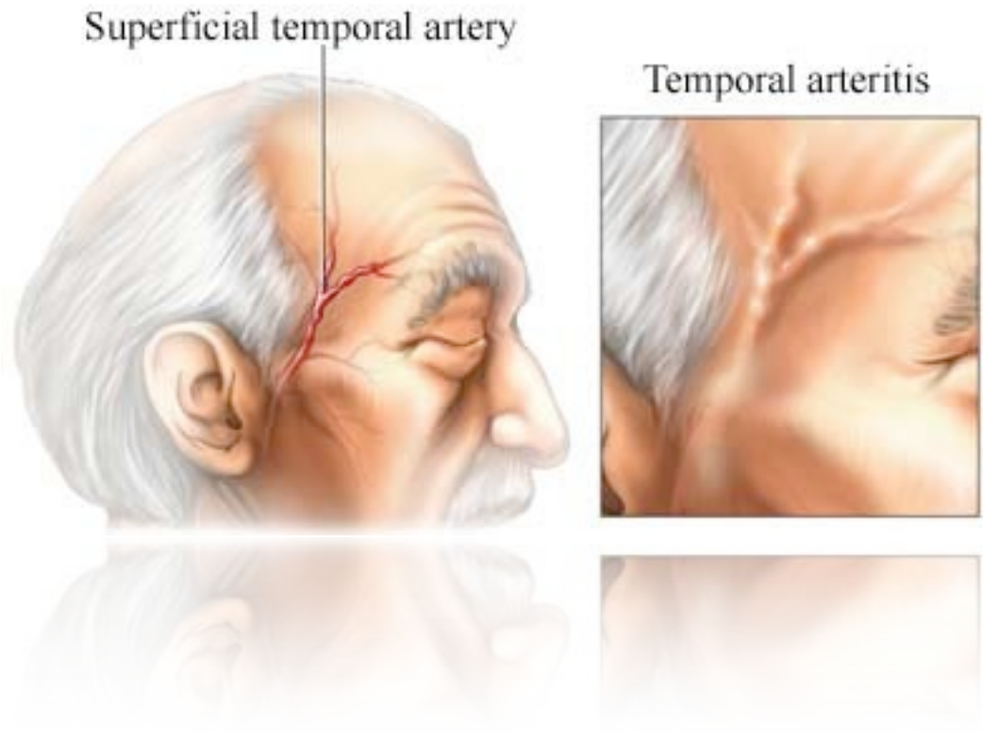
Trigeminal neuralgia

- Paroxysms last seconds
- In distribtution on trigeminal nerve
- Affected by wind/shaving/eating
- ♂:♀ 1:2
- May be secondary (14%) to aneurysm, tumour, MS, Zoster



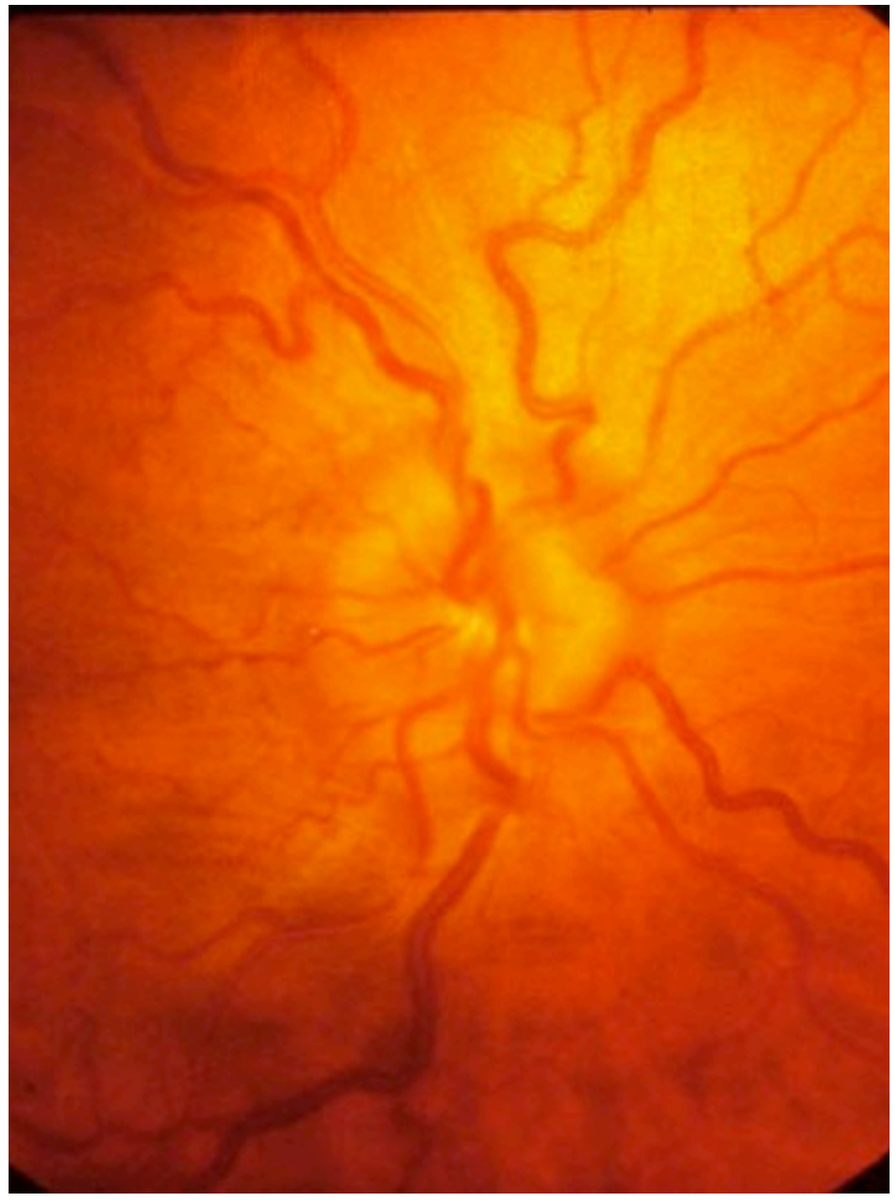
Giant Cell Arteritis

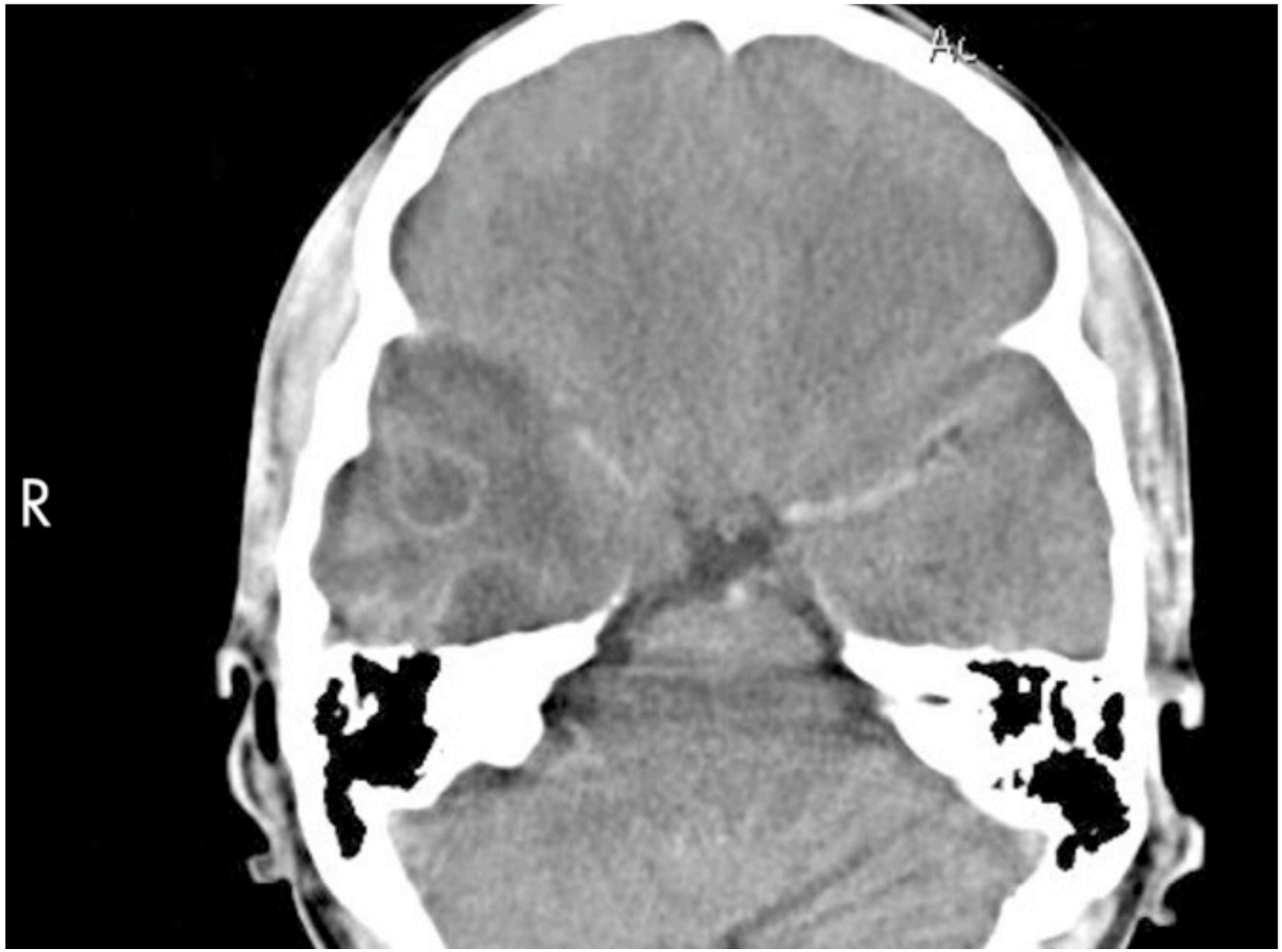
- Exclude in ALL >50yrs
- ESR raised >>40, low grade anaemia
- Need early steroids to avoid blindness: Prednisolone 40mg
- Tender, thickened, red, pulseless temporal arteries
- Ask about jaw claudication, night sweats, LOW, polymyalgia
- Refer RMO (neurologist)



Raised ICP

- Headache on waking or that wakes from sleep
- Worse on bending/lying
- May have vomiting, focal neurology, papilloedema. (Case report click here)
- Need admission, CT/MR scan





Questions?