

HEADACHES

REFERRAL GUIDELINE

MAINE MEDICAL PARTNERS - NEUROLOGY •92 CAMPUS DRIVE, SUITE B, SCARBOROUGH, ME • (207) 883-1414

HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Papilledema with negative imaging or low concern for mass lesion.

Severe temporal headache in elderly patient

Severe headache associated with neurologic deficits (CN palsies, weakness, numbness, neck pain)

EXAM:

Papilledema. Temporal artery tenderness, CN palsies, weakness, numbness, nuchal rigidity

LABS:

High WBC/inflammatory parameters

SUGGESTED PREVISIT WORKUP

Most truly urgent headache patients need ED evaluation: Severe/paroxysmal onset; fever/meningismus; altered level of consciousness; focal neurologic deficits.

Always feel free to call Neurology office emergency physician to help with triage.

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

Patient with signs and symptoms of headaches that are not clear migraine or tension headache OR there has been a suboptimal response to initial therapies OR potential treatment with Botox for intractable migraines (greater than 14 migraines/month + greater than 2 failed preventative medicine trials)

EXAM:

Non-focal neurologic exam, no papilledema or meningismus

SUGGESTED WORKUP

Referral to neurology. Due to high volume from providers throughout all of Maine as well as southern New Hampshire, wait may be up to several months.

If patient has been seen by other neurologist(s) without benefit, consider referral to tertiary headache clinic. (e.g. Darmouth Hitchcock Medical Center, Brigham and Women’s Hospital)

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Patient with clear signs and symptoms of episodic migraine or tension headache and displays expected response to NSAIDs, triptans or other pain relievers do not require consult.

Clearly migrainous visual aura with or without headache usually does not require consultation.

EXAM:

Normal neurologic exam with or without pericranial muscular tenderness

LABS:

Many imaging findings are incidental. A telephone call to review findings may save an unnecessary consultation and patient anxiety.

SUGGESTED MANAGEMENT

Trials of standard preventive pharmacologic agents by primary care provider(see below).

Consider alternative physical and/or psychologic techniques, lifestyle modification, and counseling.

Assess for analgesic overuse/rebound.

Consider and treat any secondary causes of headache including sinus disease, TMJ syndrome, sleep disorders, mood and anxiety disorders.

CLINICAL PEARLS

- Numerous preventative therapies are available for both migraine and tension type headaches and include:
- Herbal supplements: Riboflavin 200mg twice daily, Magnesium 200mg twice daily, Co-enzyme Q10 100mg twice daily
- Anticonvulsants: Topiramate 100mg nightly or 50mg twice daily, Valproic acid 250-500mg twice daily, Gabapentin 300mg three time daily, Zonisamide 100-200mg nightly
- Antihypertensives: Propranolol LA 60-120mg daily, Verapamil, ACE inhibitors
- Antidepressants: Amitriptyline/Nortriptyline 10mg-100mg nightly, Duloxetine 30-60mg daily
- Preventative agents may take up to one month to note a 50% reduction in frequency and severity of headaches. If initial agent is ineffective after two months of therapy at goal dose, then transition to alternative agent.
- Alternative therapies may include PT, massage therapy, stress reduction techniques, acupuncture

Maine Medical
P A R T N E R S

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.