Headache

START HERE

HISTORY IS KEY
Onset + time to peak
Previous episodes

EXAMINATION
ABCDE, neuro exam
Meningism + vision

RED FLAGS
Thunderclap, fever
Confusion or deficit

ANALGESIA
Avoid opioids for primary headaches

TESTS BY STORY
Bloods, CT head, LP when indicated

FIVE PRESENTATIONS TO RECOGNISE

The truth lies in the history. Not an exhaustive list.

1 MIGRAINE



POUND clues
- **P** Pulsatile
- **O** One-day (4-72 h)
- **U** Unilateral
- **N** Nausea / vomiting
- **D** Disabling

Acute treatment
Triptan + NSAID or paracetamol
Alternatively aspirin 900 mg (if suitable)
Consider metoclopramide. Avoid opioids.

2 SUBARACHNOID HAEMORRHAGE (SAH)



Red flags
- Thunderclap, peak <5 min
- Neck stiffness, vomiting
- Photophobia, collapse
- Seizure or focal deficit

Approach
Urgent non-contrast CT head + senior review
CT <=6 h, radiologist-negative: usually no LP
CT >6 h + negative: consider LP after 12 h

3 TENSION-TYPE HEADACHE



Typical clues
- Bilateral, pressing / tight
- Mild to moderate
- Not worsened by activity
- No nausea / vomiting

Treatment
Aspirin 900 mg (if suitable), paracetamol or NSAID
Nausea? Think migraine ± metoclopramide.

4 MENINGITIS



Red flags
- Fever, headache, stiff neck
- Confusion or reduced GCS
- Photophobia, seizures
- Possible petechial rash

First steps
Blood cultures. LP if safe, without delay.
IV ceftriaxone within 1 h. Escalate early.

5 GIANT CELL ARTERITIS (GCA)



Who to think of
- Age >50, new headache
- Scalp tenderness or jaw claudication
- Visual symptoms = emergency

What to do
- ESR / CRP + FBC. Do not delay steroids
- Start prednisolone 40-60 mg promptly
- Visual loss: urgent eye / IV steroid advice

ALSO REMEMBER

These are common presentations, not a complete differential.
History matters. Opioids are poor for primary headache. Beware medication overuse.