Patient presents with complaint of headache

Obtain past medical history, detailed headache history and neuro exam: 12 CN, DT reflexes and fundoscopic exam. Review drug allergies, comorbidities, contraindications.

Evaluate SNOOP² red flags*:

- Systemic symptoms (fever, weight loss) or HIV/cancer
- Neurological symptoms (focal deficits)
- Onset: sudden/abrupt
- Older (over 50)
- P5 attern change, progressive, postural, precipitated by Valsalva, pulsatile tinnitus, papilledema, pregnancy

If NO RED FLAGS, routine labs are unnecessary. Diagnose the primary headache type. Pregnancy tests recommended prior to treatment.

If RED FLAGS are identified, follow protocols for investigating secondary headache causes.

The American College of Emergency Physicians (ACER) issued recommendations on when head imaging is necessary in patients who present with acute onset headache.

ID Migraine™ Screener*

During the past three months, did you have the following with ANY of your headaches?
1. Nausea
2. Disability (inability to work or continue ADL)
3. Photophobia

- If positive* to 2 out of 3 questions: patient has a 93% chance of having migraine
- If positive* to all 3 questions: patient has 98% chance of having migraine

*refer to ICHC3 for full diagnostic criteria

Appropriate pain management, consultations and admission

CONSIDERATIONS
Does the patient have new or different headaches in the past 6 months?
- How long has the patient had this headache?
- Has any medicine been utilized to abort this headache?
- Does the patient have cutaneous allodynia?
- Does the patient take narcotics or barbital (verify in state prescription monitoring program) containing meds for headache?
- Has the patient taken a triptan or an ergotamine product in the past 24 hours?
- Does the patient have medication overuse or MOH?

Hospital Admission Criteria:
- High-frequency headache with significant disability
- Intractable vomiting • Dehydration
- New neurologic findings: ataxia, nystagmus, or syncopal symptoms
- Comorbid conditions requiring monitoring such as:
  - Severe depression
  - Barbiturate or narcotic addiction that may require hospitalization for withdrawal
  - Unable to care for self • No social support system

SEE TREATMENT ON REVERSE SIDE
1. Provide DIAGNOSIS OF MIGRAINE and its treatment (identifying triggers, lifestyle modification, prevention and attack prescriptions). Provide educational resources and references.

2. Provide a PRESCRIPTION PLAN for acute treatment at home to treat if migraine recurs or for the next attack: migraine-specific triptans or ergotamine + NSAIDs + Compazine (treating attacks early with combination therapy using non-oral and fast-acting medications works best: SC, IM, NS, PR). Never Rx opioids or analgesics contain butalbital (Fioricet/ Fiorinal/ Esgic) for migraine. Two thirds of patients discharged from the ED will experience headache recurrence within 24 hours of discharge. Oral sumatriptan 100 mg is effective in treating recurrence within 24 hours. *If responsive to IV sodium valproate, discharge home with valporic taper 250 TID x 3 days, 250 mg BID x 3 days, 250 mg QD x 3 days then stop. *If pregnant or contraindicated (do not use both) prochlorperazide or metaclopromide (2nd dose)

3. If no improvement, re-evaluate history and neuro exam again for signs of secondary headache causes (SNOOP). *If no improvement, re-evaluate history and neuro exam again for signs of secondary headache causes (SNOOP). *If no improvement, re-evaluate history and neuro exam again for signs of secondary headache causes (SNOOP).

www.MississippiMigraineCenter.com

For help with CLUSTER HEADACHE please call the Headache Center or e-mail Christina

* Visit www.mississippimigrainecenter.com/ed/ for resources, references and more detailed information on this algorithm.