# Headache Pathway

## Clinical Assessment/Management Tool for Children

Healthier Together

NHS

## Description

Headache is a common presentation in childhood. Primary headaches are most common but need to exclude serious other causes. This can usually be through history and examination.

### History

This should focus on:

- Timing
- Nature
- Quality
- Eliciting or excluding any red flags

- Full neurological examination including central and peripheral nervous system and fundi
- Exclude meningism if acute onset
- Balance and gait
- Check Blood Pressure – see APLS aide memoire
- Signs of early or delayed puberty

## Green – Low Risk

| Feature | Tension type | Migraine | Cluster |
|---|---|---|---|
| Location | Bilateral | Unilateral or bilateral, mostly frontal | Unilateral |
| Quality | Pressing | Throbbing<br>Often shorter duration attacks compared to adults | Stabbing |
| Severity | Mild to moderate | Moderate to severe | Severe |
| Duration | 30 mins to 7 days | 2 – 72 hours | 15 – 180 mins |
| Associated features | None | Nausea/vomiting, Photophobia, Phonophobia, Reversible aura<br>*Headache can be minor (even absent) with abdominal pain and/or vomiting* | Ipsilateral autonomic features (nasal congestion, lacrimation, and conjunctival injection) |

## Amber – Intermediate Risk

- Recurrent or progressive headaches unresponsive to initial advice / treatment **WITHOUT RED** features.
- Using analgesia more than 3 days a week for more than 3 months (Medication Overuse Headache)
- Psychological factors that interfere with management

## Red Flags

**History**

- Child age <4 years (headache in this age group is very unusual and may indicate serious underlying pathology)
- Waking the child from sleep; unable to return to sleep
- Brought on by coughing or straining

**• Acute Signs**

- Severe, sudden onset, incapacitating headache that doesn't respond to simple analgesia
- Signs of meningism (neck stiffness, photophobia, vomiting)
- Impaired level of consciousness or associated confusion, disorientation
- Seizure

**Neurological Signs**

- Persistent blurred/double vision or new squint
- Visual loss, papilloedema
- Focal neurological deficits – limb weakness, cranial nerve palsies
- Head tilt/torticollis
- New neurological deficit or symptoms such as weakness/loss of balance/co-ordination problems/head tilt or gait abnormalities including ataxia

**Developmental Signs**

- Change in personality/behaviour
- Decline in academic performance or regressing milestones
- Abnormal growth parameters
- Signs of early or delayed puberty

**Other Symptoms and Signs**

- High blood pressure (use APLS aide memoire)
- Persistent vomiting/nausea, especially if early morning (occurring on most days for 2 or more weeks)

## Green Actions

- Provide and discuss patient information leaflet
- Advise a routine optician appointment
- Simple headache advice as per advice sheet
- Keep analgesia use to a minimum (less than 3 days a week)
- Explore psychosocial factors/ stressors (HEEADSSS screen if >10 years
- Encourage parents/child to keep a headache diary and arrange follow up review with their GP
- There is no role for opioid analgesia (including codine)

Headaches in over 12s: Diagnosis and management

## Amber Actions

- Provide written and verbal advice, see our page on headaches
- Ensure all green actions completed
- If the frequency exceeds 2 per week and/or normal daytime activities including school attendance are heavily affected, consider an out-patient referral
- Signpost to local mental health support. Visit our emotional wellbeing pages and young person mental health pages

Headaches in over 12s: Diagnosis and management

## Red Actions

- If suspected meningitis acquire IV access and start immediate management with 100mg/kg ceftriaxone (max dose 4g) - see **Fever Guideline** for further help and active a **2222** call
- If focal neurology suggestive of an acute ischaemic stroke or intracranial bleed call the PEM Consultant/Paediatric Bleep holder. Follow the **Paediatric Stroke Guidelines RCPCH 2017**
- For other red features: discuss immediately with the PEM Consultant ot on-call paediatric team to assess urgency of neuroimaging

**This guidance has been reviewed and adapted by healthcare professionals across West Yorkshire with consent from the Hampshire development groups and updated by the PEM Team at CHT for use in PED. It is due review in October 2028.**