Headaches: diagnosis and management of headaches in young people and adults

NICE guideline

Draft for consultation, April 2012

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

Contents

Introduction

Headaches are the most common neurological problem presented to GPs and neurologists. They are painful and debilitating for individuals and, as an important cause of absence from work or school, a substantial burden on society.

Headache disorders are classified as primary or secondary. The aetiology of primary headaches is poorly understood and they are classified according to their clinical pattern. The most common primary headache disorders are tension-type headache, migraine and cluster headache. Secondary headaches are attributed to underlying disorders and include, for example, headaches associated with giant cell arteritis, raised intracranial pressure, infection and medication overuse. The major health and social burden of headaches is caused by the primary headache disorders and medication overuse headache, which often occurs in those taking medication for a primary headache disorder.

This guideline makes recommendations on the diagnosis and management of the most common primary headache disorders in young people (12 years and older) and adults. Many people with headache do not have an accurate diagnosis of headache type. Healthcare professionals can find the diagnosis of headache difficult, and both people with headache and their healthcare professionals can be concerned about possible underlying causes. Improved recognition of primary headaches will help the generalist clinician to manage headaches more effectively, allow better targeting of treatment and potentially improve patients' quality of life and reduce unnecessary investigations.

The guideline assumes that prescribers will use a drug’s summary of product characteristics to inform decisions made with individual patients.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. Where recommendations have been made for the use of drugs outside their licensed indications (‘off-label use’), these drugs are marked with a footnote in the recommendations.

Patient-centred care

This guideline offers best practice advice on the care of young people (aged 12 years and older) and adults with headaches.

Treatment and care should take into account patients' needs and preferences. People with headaches should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent (available from www.dh.gov.uk/consent) and the code of practice that accompanies the Mental Capacity Act (summary available from www.publicguardian.gov.uk). In Wales, healthcare professionals should follow advice on consent from the Welsh Assembly Government (available from www.wales.nhs.uk/consent).

If the patient is under 16, healthcare professionals should follow the guidelines in 'Seeking consent: working with children' (available from www.dh.gov.uk/consent).

Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance

described in ‘Transition: getting it right for young people’ (available from www.dh.gov.uk).

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with headaches. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Diagnosis

Tension-type headache, migraine and cluster headache

- Diagnose tension-type headache, migraine or cluster headache according to the headache features in the table. **[1.2.1]**

Medication overuse headache

- Be aware of the possibility of medication overuse headache in people whose headache developed or worsened while they were taking the following drugs for 3 months or more:
  - triptans, opioids, ergots or combination analgesic medications on 10 days per month or more
  - paracetamol, aspirin or a non-steroidal anti-inflammatory drug (NSAID), either alone or any combination, on 15 days per month or more. **[1.2.7]**

Neuroimaging

- Do not refer people diagnosed with tension-type headache or migraine (see recommendation 1.2.1) for neuroimaging unless they present with one or more of the features listed in recommendation 1.1.1. **[1.3.2]**

Management

Information and support for people with headache disorders

- Include the following in discussions with the person:
  - a positive diagnosis, including an explanation of the diagnosis and reassurance that other pathology has been excluded
  - the options for management
  - recognition that headache is a valid medical disorder that can have a significant impact on the person and their family or carers. **[1.4.3]**

Migraine

- Offer combination therapy with a triptan and an NSAID, or a triptan and paracetamol, for the acute treatment of migraine. **[1.4.9]**
- For people in whom oral preparations for the acute treatment of migraine are ineffective or not tolerated:
  - offer an intravenous or other non-oral preparation of metoclopramide, chlorpromazine[1] or prochlorperazine[2] **and**
  - consider adding a non-oral NSAID or triptan after establishing which medications have been tried. **[1.4.13]**
- Offer topiramate for the prophylactic treatment of migraine[3]. Advise women of childbearing potential that topiramate is associated with a risk of fetal malformations and ensure they are offered appropriate contraception, because topiramate interferes with hormonal contraception. **[1.4.15]**

Cluster headache

- Offer oxygen and/or a subcutaneous or nasal triptan[4] for the acute treatment of cluster headache.
  - Use 100% oxygen at a flow rate of at least 12 litres/minute with a non-rebreathing mask and a reservoir bag.
  - Ensure provision of home and/or ambulatory oxygen.
  - Ensure the person is offered an adequate supply of triptans calculated according to their history of cluster bouts, based on the manufacturer's maximum daily dose. **[1.4.26]**

[1] At the time of publication (April 2012), chlorpromazine did not have UK marketing authorisation for migraine. Informed consent should be obtained and documented.
[2] At the time of publication (April 2012), prochlorperazine did not have UK marketing authorisation for migraine. Informed consent should be obtained and documented.
[3] At the time of publication (April 2012), topiramate did not have UK marketing authorisation for migraine prophylaxis in people aged under 18 years. Informed consent should be obtained and documented.
[4] At the time of publication (April 2012), triptans did not have UK marketing authorisation for cluster headache in people aged under 18 years. Informed consent should be obtained and documented.

1 Guidance

The following guidance is based on the best available evidence. The full guideline ([hyperlink to be added for final publication]) gives details of the methods and the evidence used to develop the guidance.

All recommendations apply to adults and young people aged over 12 years unless specifically stated otherwise in the recommendation.

1.1 Assessment

1.1.1 Consider further investigations and/or referral for people who present with headache and any of the following features:

- worsening headache with fever
- sudden-onset headache
- new-onset neurological deficit
- new-onset cognitive dysfunction
- change in personality
- impaired level of consciousness
- recent head trauma
- headache triggered by cough, valsalva (trying to breathe out with nose and mouth blocked) or sneeze
- headache triggered by exercise
- headache that changes with posture
- age 50 years or older and could have giant cell arteritis
- severe eye pain and could have acute narrow-angle glaucoma
- a substantial change in the characteristics of their headache.

1.1.2 Consider further investigations and/or referral for people who present with new-onset headache and any of the following:

- compromised immunity, caused, for example, by HIV or immunosuppressive drugs
- age under 20 years and a history of malignancy
- a history of malignancy known to metastasise to the brain
- vomiting without other obvious cause.

1.1.3 Consider using a headache diary to aid the diagnosis of primary headaches.

1.1.4 If a headache diary is used, ask the person to record the following for a minimum of 8 weeks:

- frequency, duration and severity of headaches
- any associated symptoms
- medications taken to relieve headaches
- possible precipitants
- relationship of headaches to menstruation.

1.2 Diagnosis

Tension-type headache, migraine and cluster headache

1.2.1 Diagnose tension-type headache, migraine or cluster headache according to the headache features in the table.

Table Diagnosis of tension-type headache, migraine and cluster headache

Headache feature	Tension-type headache		Migraine		Cluster headache	
Pain location[a]	Bilateral		Unilateral or bilateral		Unilateral (around the eye, above the eye and along the side of the head/face)	
Pain quality	Pressing/tightening (non-pulsating)		Pulsating (throbbing or banging in young people aged 12–18 years)		N/A	
Pain intensity	Mild or moderate		Moderate or severe		Severe or very severe	
Effect on activities	Not aggravated by routine activities of daily living		Aggravated by, or causes avoidance of, routine activities of daily living		Restlessness or agitation	
Other symptoms	None		Unusual sensitivity to light and/or sound or nausea and/or vomiting		On the same side as the headache: • Red and/or watery eye • Nasal congestion and/or runny nose • Swollen eyelid • Forehead and facial sweating • Constricted pupil and/or drooping eyelid.	
Duration	30 minutes–continuous		4–72 hours (1–72 hours in young people aged 12 to 18 years)		15–180 minutes	
Frequency	< 15 days per month	≥ 15 days per month for more than 3 months		< 15 days per month	One every other day to eight per day[b], with remission[c] > 1 month	One every other day to eight per day[b], with remission[c] < 1 month in a 12-month period
Diagnosis	**Episodic tension-type headache**	**Chronic migraine or chronic tension type headache[d]**		**Episodic migraine**	**Episodic cluster headache**	**Chronic cluster headache**

[a] Headache pain can be felt in the head, face or neck

[b] A cluster headache bout.

[c] The pain-free period between cluster headache bouts.

[d] Chronic migraine and chronic tension-type headache commonly overlap. If there are any features of migraine, diagnose chronic migraine.

Migraine with aura

1.2.2 Suspect aura in people who present with or without headache and with neurological symptoms that:

- are fully reversible
- develop gradually, either alone or in succession, over at least 5 minutes and
- last for 5–60 minutes.

1.2.3 Diagnose migraine with aura in people who present with or without headache and with one or more of the following typical aura symptoms that meet the criteria in recommendation 1.2.2:

- visual symptoms that may be positive (for example, flickering lights, spots or lines) and/or negative (for example, loss of vision)
- sensory symptoms that may be positive (for example, pins and needles) and/or negative (for example, numbness)
- speech disturbance.

1.2.4 Consider further investigations and/or referral for people who present with or without headache and with any of the following atypical aura symptoms that meet the criteria in recommendation 1.2.2:

- fully reversible motor weakness
- slurred speech
- double vision
- visual symptoms affecting only one eye
- poor balance
- decreased level of consciousness.

Menstrual-related migraine

1.2.5 Suspect menstrual-related migraine in women whose migraine occurs predominantly between 2 days before and 3 days after the

start of menstruation in at least two out of three consecutive menstrual cycles.

1.2.6 Diagnose menstrual-related migraine using a headache diary (see recommendation 1.1.4) for at least two menstrual cycles.

Medication overuse headache

1.2.7 Be aware of the possibility of medication overuse headache in people whose headache developed or worsened while they were taking the following drugs for 3 months or more:

- triptans, opioids, ergots or combination analgesic medications on 10 days per month or more
- paracetamol, aspirin or a non-steroidal anti-inflammatory drug (NSAID), either alone or in any combination, on 15 days per month or more.

1.3 Neuroimaging

1.3.1 Do not refer people diagnosed with tension-type headache, migraine, cluster headache or medication overuse headache for neuroimaging solely for reassurance.

1.3.2 Do not refer people diagnosed with tension-type headache or migraine (see recommendation 1.2.1) for neuroimaging unless they present with one or more of the features listed in recommendation 1.1.1.

1.3.3 Discuss the need for neuroimaging for people with a first bout of cluster headache with a GP with a special interest or a neurologist.

1.3.4 Do not refer people with a history of repeated bouts of cluster headache (see recommendation 1.2.1) for neuroimaging unless they present with one or more of the features listed in recommendation 1.1.1.

1.4 Management

All headache disorders

1.4.1 Consider using a headache diary:

- to record the frequency, duration and severity of headaches
- to monitor the effectiveness of headache interventions
- as a basis for discussion with the person about their headache disorder and its impact.

1.4.2 Consider further investigations and/or referral if a person diagnosed with a headache disorder develops any of the features listed in recommendation 1.1.1.

Information and support for people with headache disorders

1.4.3 Include the following in discussions with the person:

- a positive diagnosis, including an explanation of the diagnosis and reassurance that other pathology has been excluded
- the options for management
- recognition that headache is a valid medical disorder that can have a significant impact on the person and their family or carers.

1.4.4 Give the person written and oral information about headache disorders, including directions to support organisations and internet resources.

1.4.5 Explain the risk of medication overuse headache to people who are using acute treatments for their headache disorder.

Tension-type headache

1.4.6 Offer aspirin, paracetamol or an NSAID for the acute treatment of tension-type headache, taking into account the person's preference, comorbidities and risks of adverse events.

1.4.7 Do not offer opioids for the acute treatment of tension-type headache.

1.4.8 Consider a course of up to ten sessions of acupuncture for the prophylactic treatment of tension-type headache.

Migraine

1.4.9 Offer combination therapy with a triptan and an NSAID, or a triptan and paracetamol, for the acute treatment of migraine.

1.4.10 For people who prefer to take only one drug, consider monotherapy with a triptan, an NSAID, aspirin (900 mg) or paracetamol for the acute treatment of migraine if these drugs have not already been tried as monotherapy.

1.4.11 Consider an anti-emetic in addition to combination therapy or monotherapy for the acute treatment of migraine.

1.4.12 Do not offer ergots or opioids for the acute treatment of migraine.

1.4.13 For people in whom oral preparations for the acute treatment of migraine are ineffective or not tolerated:

- offer an intravenous or other non-oral preparation of metoclopramide, chlorpromazine[5] or prochlorperazine[6] **and**
- consider adding a non-oral NSAID or triptan after establishing which medications have been tried.

1.4.14 Discuss the benefits and risks of prophylactic treatment for migraine with the person, taking into account the impact of the headache on their quality of life and the choice of treatment available.

[5] At the time of publication (April 2012), chlorpromazine did not have UK marketing authorisation for migraine. Informed consent should be obtained and documented.
[6] At the time of publication (April 2012), prochlorperazine did not have UK marketing authorisation for migraine. Informed consent should be obtained and documented.

1.4.15 Offer topiramate for the prophylactic treatment of migraine[7]. Advise women of childbearing potential that topiramate is associated with a risk of fetal malformations and ensure they are offered appropriate contraception, because topiramate interferes with hormonal contraception.

1.4.16 Offer propranolol to people who are unable to tolerate topiramate or for whom it is unsuitable.

1.4.17 If both topiramate and propranolol are unsuitable or ineffective, consider a course of up to ten sessions of acupuncture, gabapentin[8] (up to 1200 mg per day), or telmisartan[9] (80 mg per day).

1.4.18 Tell people with migraine that butterbur (50 mg twice a day), trimagnesium dicitrate (600 mg once a day) and riboflavin (400 mg once a day) may be effective in reducing migraine frequency and intensity for some people.

1.4.19 For people who are already having treatment with another form of prophylaxis such as amitriptyline[10], and whose migraine is well controlled, continue the current treatment.

Combined hormonal contraceptive use in women with migraine

1.4.20 Do not routinely offer combined hormonal contraceptives for contraception to women who have migraine with aura.

1.4.21 Consider alternatives to combined hormonal contraception for women who have migraine without aura and risk factors for stroke and who require contraception.

[7] At the time of publication (April 2012), topiramate did not have UK marketing authorisation for migraine prophylaxis in people aged under 18 years. Informed consent should be obtained and documented.
[8] At the time of publication (April 2012), gabapentin did not have UK marketing authorisation for migraine. Informed consent should be obtained and documented.
[9] At the time of publication (April 2012), telmisartan did not have UK marketing authorisation for migraine. Informed consent should be obtained and documented.
[10] At the time of publication (April 2012), amitriptyline did not have UK marketing authorisation for migraine. Informed consent should be obtained and documented.

Menstrual-related migraine

1.4.22 For menstrual-related migraine that does not respond adequately to acute treatment, consider prophylactic treatment with frovatriptan (2.5 mg twice a day) or zolmitriptan (2.5 mg twice or three times a day) on the days migraine is expected.

Treatment of migraine during pregnancy

1.4.23 Offer pregnant women the same acute treatment for migraine as non-pregnant women, taking into account the woman's need for treatment and the risks associated with the use of aspirin and NSAIDS during pregnancy.

1.4.24 Do not offer topiramate for the prophylactic treatment of migraine during pregnancy.

1.4.25 Refer the woman to a specialist if prophylactic treatment for migraine is needed during pregnancy.

Cluster headache

1.4.26 Offer oxygen and/or a subcutaneous or nasal triptan[11] for the acute treatment of cluster headache.

- Use 100% oxygen at a flow rate of at least 12 litres/minute with a non-rebreathing mask and a reservoir bag.
- Arrange provision of home and/or ambulatory oxygen.
- Ensure the person is offered an adequate supply of triptans calculated according to their history of cluster bouts, based on the manufacturer's maximum daily dose.

1.4.27 Do not offer paracetamol, NSAIDS, opioids, ergots or oral triptans for the acute treatment of cluster headache.

[11] At the time of publication (April 2012), triptans did not have UK marketing authorisation for cluster headache in people aged under 18 years. Informed consent should be obtained and documented.

1.4.28 Consider verapamil[12] for prophylactic treatment during a bout of cluster headache, seeking early specialist telephone advice if unfamiliar with the use of verapamil for cluster headache.

1.4.29 Seek specialist advice for cluster headache that does not respond to verapamil.

1.4.30 Seek specialist advice for the treatment of cluster headache during pregnancy.

Medication overuse headache

1.4.31 Explain to people with medication overuse headache that it is treated by withdrawing overused medication.

1.4.32 Tell people to stop taking all overused acute headache medications for at least 1 month and to stop abruptly rather than gradually.

1.4.33 Tell people that headache symptoms are likely to get worse in the short term before they improve and that there may be associated withdrawal symptoms, and provide them with close follow-up and support according to their needs.

1.4.34 Consider prophylactic treatment as an adjunct to withdrawal of overused medication for people with medication overuse headache and a primary headache disorder.

1.4.35 Do not routinely offer inpatient withdrawal for medication overuse headache.

1.4.36 Consider specialist referral and/or inpatient withdrawal of overused medication for people who are using strong opioids, or have comorbidities, or in whom previous repeated attempts at withdrawal of overused medication have been unsuccessful.

[12] At the time of publication (April 2012), verapamil did not have UK marketing authorisation for cluster headache. Informed consent should be obtained and documented.

1.4.37 Review the diagnosis of medication overuse headache and further management 4–8 weeks after the start of withdrawal of overused medication.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

The guideline covers diagnosis and management of primary headache and medication overuse headache in young people and adults aged 12 or over. Particular consideration is given to girls and women of reproductive age.

How this guideline was developed

NICE commissioned the National Clinical Guideline Centre to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

3 Implementation

NICE has developed tools to help organisations implement this guidance.

Note: these details will apply when the guideline is published.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 Amitriptyline to prevent recurrent migraine

Is amitriptyline a clinically and cost effective prophylactic treatment for recurrent migraine?

Why this is important

Effective prevention has the potential to make a major impact on the burden of disability caused by recurrent migraine. There are few pharmacological agents that have been proven to prevent recurrent migraine.

Amitriptyline is widely used, off-label, to treat chronic painful disorders, including migraine. Inadequate evidence was found in the review for this guideline for the effectiveness of amitriptyline in the prophylaxis of migraine. A double-blind randomised controlled trial (RCT) is needed to assess the clinical and cost effectiveness of amitriptyline compared with placebo. The International classification of headache disorders II classification of migraine should be used and outcomes should include change in patient-reported migraine days, responder rate and incidence of serious adverse events. If amitriptyline is shown to be effective, it will widen the range of therapeutic options, in particular for people in whom recommended medications are ineffective or not tolerated.

4.2 Psychological interventions to manage chronic headache disorders

Does a psychological intervention such as cognitive behavioural therapy (CBT) improve headache outcomes and quality of life for people with chronic headache disorders?

Why this is important

Psychological interventions such as CBT are widely recommended for people living with chronic painful disorders. An effective psychological intervention based on cognitive behavioural principles for people living with chronic headache disorders has the potential to substantially improve their quality of life. There are few data to support the use of these interventions to manage chronic headache disorders.

A pragmatic RCT is needed to assess the impact of a psychological intervention compared with an active control. Mood disorders are commonly comorbid with headache disorders, but the trial needs to address the impact of a psychological intervention on headache alone, using appropriate headache outcomes such as change in patient-reported headache days and headache-specific quality of life.

4.3 Exercise programmes to manage chronic headache disorders

Does an exercise programme added to usual care improve headache outcomes and quality life for people with chronic headache disorders (chronic migraine, chronic tension-type headache or medication overuse headache)?

Why this is important

There are some data supporting the use of exercise programmes in the treatment of chronic headache disorders. These data are not directly applicable to the UK and are based on interventions that are unlikely to be practicable in the NHS. Nevertheless, exercise shows potential as a non-pharmacological approach to the management of chronic pain disorders and has been shown to be effective in reducing chronic low back pain. If exercise programmes are effective for people living with chronic headache disorders, they have the potential to substantially improve quality of life at low cost.

An RCT is needed to assess the clinical and cost effectiveness of exercise as a complex intervention in the treatment of chronic headache disorders. A programme of work will be required before the RCT to identify an appropriate exercise programme. Headache outcomes such as change in patient-reported headache days, responder rate and headache-specific quality of life should be included.

4.4 Education and self-management to manage chronic headache disorders

Does an education and self-management programme improve headache outcomes and quality of life for people with chronic headache disorders (chronic migraine, chronic tension-type headache or medication overuse headache)?

Why this is important

There are few data to support the use of non-pharmacological approaches to the management of chronic headache disorders. Self-management programmes that include education and self-care advice are widely recommended for people living with chronic painful disorders but are potentially costly. A study of the clinical and cost effectiveness of self-management programmes for people with chronic headache disorders has the potential to substantially improve their quality of life.

An RCT is required to compare an education and self-management package with usual care. Before any trial there will need to be a programme of work to develop and evaluate an appropriate treatment package and to decide on the most appropriate outcome measures to be used. Headache outcomes such as change in patient-reported headache days, responder rate and headache-specific quality of life should be included.

4.5 Pharmacological headache prophylaxis to aid withdrawal treatment in medication overuse headache

Do pharmacological treatments used for headache prophylaxis help people with medication overuse headaches withdraw from medication?

Why this is important

Medication overuse headache is a common disorder. Current best advice is for abrupt withdrawal without any supportive pharmacological treatment. Many people with medication overuse headache find it challenging to withdraw abruptly because in the short term their headaches can become much worse.

For those who have an underlying headache disorder such as migraine or tension-type headache, the use of appropriate prophylactic treatment may aid withdrawal.

A double-blind RCT is needed in people with suspected medication overuse headache who have an identifiable primary headache disorder. The trial should compare withdrawal plus placebo with withdrawal plus prophylactic medication. Outcomes should include change in acute medication use, proportion of participants who no longer have suspected medication overuse headache, change in patient-reported headache days and headache-specific quality of life.

5 Other versions of this guideline

5.1 Full guideline

The full guideline Headaches: diagnosis and management of headaches in young people and adults contains details of the methods and evidence used to develop the guideline. It is published by the National Clinical Guideline Centre. Note: these details will apply to the published full guideline.

5.2 NICE pathway

The recommendations from this guideline will be incorporated into a NICE pathway. Note: these details will apply when the guideline is published.

5.3 'Understanding NICE guidance'

A summary for patients and carers ('Understanding NICE guidance') is available.

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about headaches.

6 Related NICE guidance

Published

- Patient experience in adult NHS services. NICE clinical guideline 138 (2012).

- The epilepsies. NICE clinical guideline 137 (2012).
- Hypertension. NICE clinical guideline 127 (2011).
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011).
- Percutaneous closure of patent foramen ovale for recurrent migraine. NICE interventional procedure guidance 370 (2010).
- Depression in adults. NICE clinical guideline 90 (2009).
- Glaucoma. NICE clinical guideline 85 (2009
- Medicines adherence. NICE clinical guideline 76 (2009).
- Head injury. NICE clinical guideline 56 (2007).
- Referral guidelines for suspected cancer. NICE clinical guideline 27 (2005).

Under development

NICE is developing the following guidance (details available from www.nice.org.uk):

- Botulinum type A for the prophylaxis of headaches associated with chronic migraine. NICE technology appraisal guidance. Publication expected June 2012.

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations. Please see our website for information about updating the guideline.

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