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If you have a prior history of migraine headaches, you're more likely to have migraines during pregnancy. It would be unusual, though – but not unheard of – to have a migraine for the first time during pregnancy.

Of course, if the headaches start during pregnancy, they'll likely continue after, according to **Dr. Howard Derman, the director of the Headache Clinic at Methodist Neurological Institute in Houston, Texas.**

Indeed, it is estimated that a quarter of reproductive-age women have migraines, according to Dr. Meghan Hayes, with Obstetric and Consultative Medicine at Women and Infants' Hospital in Providence, R.I. Over 80 percent of women in this demographic have headaches – with tension-type headaches being most common, followed by migraine. "Thus, we see migraines often in pregnant women," Dr. Hayes says.

What Causes Headaches?

Headaches early in pregnancy are common, caused by hormonal changes, sleep interruption and sometimes caffeine withdrawal, Dr. Hayes says. These, however, are most commonly tension-type headaches that will improve with rest, drinking more fluids, relaxation/stress reduction measures and acetaminophen if needed.

Caffeine withdrawal headaches tend to be migraines, with blood vessel spasm the culprit. But this pain can be avoided. Dr. Hayes says that consuming up to two cups of coffee or an equivalent caffeine source per day is acceptable during pregnancy.

Some women have menstrual migraines that are thought to be triggered by estrogen decline. "Pregnancy, with sustained increase in estrogen levels, may lead to improvement in migraines for these women," Dr. Hayes says. "After delivery, they are likely to experience more frequent and/or severe migraines."

When Should You Worry?

If women who experience migraines experience a change in headache pattern during pregnancy, Dr. Hayes says they require evaluation to exclude other causes of headache, such as the following:

- Pre-eclampsia if after 20 weeks of gestation – characterized by high blood pressure, elevated urine protein and sometimes rapid increase in swelling and sometimes accompanied by new headache, visual changes such as blurring or spots, right upper abdominal pain.
- Pseudotumor cerebri – increased pressure inside the brain.
- Intracerebral hemorrhage – increased blood volume in pregnancy may contribute to rupture of preexisting arteriovenous malformations or aneurysms.
- Infectious causes of headache – such as meningitis or sinusitis.
- Cerebral venous thrombosis – blood clot in a vein around the brain.

"Pregnant women are at increased risk of all of these other causes of headache, so anyone with 'worst headache of her life' or a significant change in headaches needs prompt evaluation," Dr. Hayes says.

Liane Worthington, who lives near Scranton, Pa., had never had a migraine until her first pregnancy. She was young and fairly healthy, but at 32 weeks pregnant, she developed a strange headache that became a migraine complete with vomiting, dizziness and incoherence. "I developed toxemia, a full-blown case (complete with seizure a day later)," Worthington says. There were no indications of the condition until she got her migraine, when her blood pressure soared and triggered the headache. She had to deliver her daughter seven weeks early by emergency C-section, but they both recovered quickly and had no complications afterwards. In fact, Worthington went on to have two more kids without complications.

A change in headache pattern was also a clue for Natasha Baker of Dayton, Ohio. Baker has had menstrual migraines since she was 12, but pregnancy actually resulted in more tolerable migraines. In month 4, with both of her pregnancies, the migraines slowed down. "However, I started getting them again in the last week of the pregnancy," Baker says. "They were actually a trigger to my doctor that it was time to schedule the C-section. At that point, I had elevated blood pressure and increased swelling – all symptoms of pre-eclampsia."

What Are the Treatment Options?

"Standard medications used for migraines such as triptans, anticonvulsants and calcium-channel blockers are not suggested as treatments during pregnancy because of the possible risk to the fetus," Dr. Derman says. "Under no circumstances should patients be started on a daily scheduled medication during pregnancy."

It is suggested that women who are taking preventive medications for migraine discuss options with their physician prior to pregnancy. Dr. Hayes says that if a daily preventive medication is needed, amitriptyline (Elavil) at low doses has a long track record in pregnancy, as do beta blockers. Beta blockers such as metoprolol, atenolol and propranolol have not been associated with fetal malformations but may contribute to decreased growth in the fetus, so close monitoring of fetal growth with ultrasound is recommended, she says.

Baby aspirin, 81 milligrams daily, may help prevent migraine headaches and is reasonable during pregnancy, Dr. Hayes says. She also recommends acetaminophen 1,000 milligrams by mouth plus metoclopramide (Reglan, a prescription anti-nausea medication) 10 milligrams by mouth and a caffeine-containing drink at the onset of a migraine headache, then rest in a quiet, dark room. This and other anti-nausea medications are "commonly used for acute migraine treatment in emergency departments; these medications are reasonable during pregnancy," Dr. Hayes says. "No published studies have evaluated the effectiveness of anti-nausea medications for migraine treatment in pregnant women."

For acute headache treatment, non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and naproxen are not recommended during pregnancy, particularly beyond the second trimester, due to concerns for early closure of the ductus arteriosus (important for fetal heart-lung flow), low amniotic fluid levels and effects on fetal kidneys, Dr. Hayes says. The same goes for full-sized aspirin.

Of course, there's always non-pharmacological therapy. "There's good evidence that supports the use of relaxation training, biofeedback training and cognitive behavioral therapy in the treatment of migraine," says Dr. Brian Grosberg, director of the Impatient Headache Program, Montefiore Headache Center in the Bronx, N.Y. "Non-pharmacological behavioral management of headache should be recommended as a standard adjunctive treatment for all women with migraine that are pregnant or planning on becoming pregnant," Dr. Grosberg says. "It is best if these techniques can be taught and used by the patient before pregnancy commences."

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