

The pregnancy/migraine issue (answers on page 42)

Part one

Alia, a 23-year-old teacher, often has severe migraines. She has no aura, and the headaches are accompanied by severe nausea and vomiting. She would like to conceive, but is worried that pregnancy will make her headaches worse, and that her current preventive treatment might harm a developing foetus. She has come to you for advice, and has a few questions to ask. What would be your replies?

- Q1 How will pregnancy affect my migraines?**
- (a) The attacks will probably increase and become more severe.
 - (b) They are more likely than not to become less frequent and less severe, and even disappear altogether.
 - (c) The fact that she has no aura is helpful, in that migraines of this type are more likely than most to improve during pregnancy.
 - (d) Many women find their attacks increase in the first 3 months, then decrease thereafter.
 - (e) For a very few women, migraine with aura develops for the first time in the last 3 months of pregnancy.

Part two

- Q2 What are the risks of my usual anti-migraine treatments if I become pregnant? Which of these statements are true?**
- (a) Ergotamine is absolutely contraindicated.
 - (b) Paracetamol is safe for the embryo but is probably ineffective in migraine in pregnancy.
 - (c) Sumatriptan has been found not to raise the rate of birth defects in women who took it during the first trimester or in the period just before conception.
 - (d) Non-steroidal anti-inflammatories such as ibuprofen and naproxen show no evidence of risk to the human foetus during early pregnancy.
 - (e) The safety of serotonin antagonists such as pizotifen and methysergide in pregnancy has not been established.
 - (f) Valproate should not be used in pregnancy.

Part three

Nausea and vomiting are common both to pregnancy and to migraine. They feature highly and distressingly already in Alia's migraine attacks and she is fearful that they will worsen during a pregnancy.

- Q3 Which of the following statements are correct about hyperemesis gravidarum and migraine?**
- (a) Pregnancy usually decreases the nausea associated with migraine attacks.
 - (b) Alia can expect her migraine nausea to be much worse if it happens during pregnancy, to the extent that she may become seriously dehydrated.
 - (c) Opioids are effective and relatively safe for migraine nausea in pregnancy.
 - (d) Prochlorperazine can be effective, and is also safe, during pregnancy migraine attacks.
 - (e) All anti-emetics are teratogenic and should not be given in pregnancy even for nausea.

Part four

Alia wants to breast feed. She is concerned that her current anti-migraine treatments might appear in the milk and harm her baby.

- Q4 Which of the following statements are true of migraines occurring postpartum?**
- (a) About a third of women with a history of migraines develop a postpartum headache 3 to 6 days after the birth, which is frontal, and not one-sided, with photophobia, nausea and anorexia.
 - (b) The most effective treatment for postpartum migraine is sumatriptan by injection.
 - (c) Of the betablockers used regularly to prevent migraine attacks, atenolol is probably not Alia's treatment of choice during breast feeding.
 - (d) Valproate can be re-started as a migraine preventive, but probably not topiramate.

Part five

- Q5 There have been claims that migraine is associated with certain pregnancy-related abnormalities. In which of the following has the association been proved?**
- (a) Pre-eclampsia. (b) Miscarriage. (c) Congenital abnormalities. (d) Low birthweight.

Alia and her doctor considered the answers to her questions, and she and her husband decided to go ahead. Two years later she has her first son, after a happy and virtually migraine-free pregnancy. Interestingly, she has not had a migraine since the birth, 8 months ago.