



HEADACHES AND PREGNANCY

Many women suffer from headaches. Types of headaches include tension headaches, cluster headaches, migraine headaches, and sinus headaches, as well as those caused by eye disorders and severe neurological disease. Many women suffer from mild headaches early in pregnancy. While the exact cause of the headache is unclear and often cannot be elucidated, the majority of these headaches are relieved when treated symptomatically. Most mild pregnancy-related headaches abate or even resolve in the second trimester.

Ninety percent of headaches are classified as either tension or migraine headaches. As many as 18% of women suffer from a migraine headache at some point in their lives. Migraine headaches appear to be the most common severe headache in pregnancy. Fifteen to twenty percent of pregnant women are affected by migraine headaches.

Q. WHAT ARE MIGRAINE HEADACHES?

A. Migraine headaches are vascular headaches. The exact cause of migraine headaches is unclear, but the theory is that there is an initial constriction of the arteries to the brain resulting in a decrease in blood flow that results in some neurological symptoms. Subsequently, there is a dilatation of the arteries leading to the brain with a resultant increase in blood flow to the brain. It is thought that this spasming of the blood vessels is what results in migraine headaches.

DIAGNOSIS OF MIGRAINE HEADACHES

Migraine headaches are diagnosed based on symptoms. Women who experience migraines often have one of two different types. These two types include migraines with aura and migraines without aura. Migraines with aura are migraines with associated neurological symptoms including associated smells, visual changes, and isolated body weakness. Most women describe their headaches as a severe throbbing headache usually on one side of their head. Often, the women experience nausea and vomiting, have photophobia (discomfort with bright light which causes them to seek a dark room), and are unable to tolerate loud noise. Many women have already been diagnosed with migraine headaches prior to pregnancy.

NATURAL HISTORY OF MIGRAINE HEADACHES IN PREGNANCY

Migraine headaches often improve during pregnancy. Studies have shown between 60 and 80% of patients notice significant improvement, if not complete resolution of their headaches in pregnancy. Additionally, women who have worse migraine symptoms at the time of menses are more likely to notice improvement in their symptoms with pregnancy.

TREATMENT OF HEADACHES IN PREGNANCY

Most migraine headaches improve significantly with pregnancy. However, some women will continue to be symptomatic during pregnancy and will require treatment for their migraines. Several treatment options are available for the pregnant women with migraine headaches.

Many women respond to acetaminophen (Tylenol) when taken early in the course of the headache. This is clearly the safest treatment for pregnant women experiencing headaches. If unresolved with Tylenol alone, anti-nausea medications such as phenergan or compazine may be added to the treatment regimen. If the pain persists or the headache is severe, your physician may prescribe a narcotic such as codeine or meperidine (Demerol) in conjunction with the anti-nausea medication. Often this is enough to relieve the symptoms. It is important to realize that this combination has severe sedative effects, and that you should not drive a car or operate any dangerous machinery when using this combination of medications. Your physician may use beta-blockers (such as labetalol or propranolol) or calcium channel blockers (such as nifedipine) to safely treat your headache.

Other treatments for migraine headaches have not been adequately studied in pregnant women, but may be offered to you by your physician if the above treatment options prove unsuccessful. These include sumatriptan (Imitrex), which is given in a subcutaneous injection and usually takes effect within 2 hours. Your physician may offer you an ergotamine derived medication. These medicines have been shown to be extremely effective in nonpregnant women. However, these medicines have some theoretical adverse risks to pregnancy, related to their constricting properties and contraction-inducing properties, and should be used cautiously.

Finally, it has been shown that some dietary components may exacerbate migraine headaches. If you are aware of certain foods that trigger your migraines, these foods should be avoided. Often, these foods include red wine (which should also be avoided in pregnancy due to alcohol content), cured meats, and certain cheeses.

ALTERNATE CAUSES OF HEADACHES IN PREGNANCY

It is extremely important to make an accurate diagnosis when dealing with headaches. First, severe neurological disease must be ruled out when dealing with new onset of headache with associated neurological. The diagnosis of migraine with aura must not be given until other potential causes have been ruled out.

Pregnancy-related diseases should be ruled out as a cause for new onset of headache in pregnancy. Specifically, it is important to rule out preeclampsia (known in the past as toxemia), a pregnancy-related disorder that can be very serious. Mild cases of preeclampsia present with elevated blood pressure at an office visit, proteinuria (a microscopic finding of protein in your urine), and nondependent edema (significant swelling of the hands and face). As preeclampsia progresses to a more severe form, a woman may develop headaches in association with multiple other symptoms. These headaches are unrelieved by symptomatic medications such as Tylenol. It is very important to mention an unrelenting headache to your

physician, especially late in pregnancy, since this pregnancy-related disorder can result in significant complications including fetal death and maternal convulsions.

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