TITLE: Headache in Pregnancy

Subtitle: Prevention of primary headache

SUMMARY: Patients often report improvement in primary HA during pregnancy. A patient’s “usual” medications for primary HA prevention should be reviewed for safety in pregnancy and consideration may be given to continuing, decreasing, stopping, or changing treatment. Non-pharmacologic options should also be explored.

Rationale: The 3 primary headache (HA) disorders including migraine, tension, and cluster type, along with other trigeminal autonomic cephalgias account for 90% of recurring and chronic HA in reproductive age women. HA decreases in pregnancy for 30-80 % of sufferers with a greater reduction reported for migraine than tension-type HA. Nonetheless, some patients experience such disruptive or numerous HA that frequent acute medication use exposes the patient to risk for rebound or medication overuse HA and prophylactic medication should be considered.

Eligible patients: Pregnant patients with known migraine, tension, or cluster HA preceding pregnancy, disruptive or frequent enough to warrant prevention strategies prior to or during pregnancy.

Contraindications: Pregnant people with secondary HA which can result from exacerbation of a preexisting medical condition, the initial manifestation of a primary central nervous system-related problem or a neurologic problem unique to pregnancy.

Technique:

1. Nonpharmacologic interventions: limited data to support use but appear safe in pregnancy
	1. Lifestyle modifications such adequate hydration and sleep, stress management, relaxation techniques, avoidance of triggers, cognitive behavioral therapy
	2. Accupuncture
	3. Biofeedback
2. Medications- no published data for HA prevention efficacy but appear safe in pregnancy based on use in other conditions
	1. First Line
		1. Antihistamines: diphenhydramine
		2. Calcium channel blockers: amlodipine, nifedipine, verapamil
		3. Magnesium
	2. Beta blockers: metoprolol, labetalol, propranolol

Special Considerations:

1. Tricyclic antidepressants, SNRIs, and antiepileptic medications require exhaustion of other strategies and acceptance of higher fetal and neonatal risks. Recommend neurology consultation before using
2. A patient with a pre-existing HA disorder who presents with a change in HA intensity or quality, or new onset neurological symptoms must be considered to have a secondary HA and requires a different evaluation and treatment paradigm.

References: ACOG Clinical Practice Guideline No. 3: Headache in Pregnancy and Postpartum. Obstet Gynecol 139 (5): 944-972. May 2022.

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