PRIMARY CARE
WOMEN'S HEALTH FORUM

THIS RESOURCE IS INTENDED FOR UK HEALTHCARE PROFESSIONALS ONLY

TOP TIPS

for Managing Headache in Pregnancy

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Top Tips for Managing Headache in Pregnancy

1.

Take a clinical history and do not rely on a self-diagnosis.

2.

Features of a migraine include:

a. Fully reversible episodes of headache lasting 4–72 hours.
b. Throbbing, unilateral or bilateral headaches.
c. Recurrent headaches that are moderate to severe.
d. Unusual sensitivity to light or sound; nausea and vomiting.
e. Aura: symptoms can occur with or without headache and
   i. Are fully reversible.
   ii. Develop over at least 5 minutes.
   iii. Last 5–60 minutes.
   iv. Typical aura includes visual symptoms (flickering lights, zig zag lines) and sensory symptoms (such as numbness, pins and needles and speech disturbance).
f. Long history of similar attacks but well spaced between each episode.
g. May be aggravated by certain activities of daily living.
h. Absence of red flags.

3.

Primary headache disorders such as migraines and tension headaches usually improve in pregnancy.

4.

If the headache does not fit into a primary headache disorder such as migraine, Cluster Headache or Tension Headache, consider a secondary headache disorder as a cause for the pregnant persons symptoms. These could include:

a. Hypertension or pre-eclampsia.
b. Idiopathic intracranial hypertension.
c. Subarachnoid haemorrhage.
d. Cerebral venous sinus thrombosis.
e. Meningitis.
f. Reversible cerebral vasoconstriction syndrome.
g. Pituitary disease.

5.

Investigations for headaches; head CT, head MRI and lumbar puncture are not contraindicated in pregnancy.

6.

Be aware of your red flags for urgent referral to the emergency department:

a. Sudden onset, peak intensity <1 minute.
b. Fever/meningism.
c. Orthostatic headache.
d. Neurological deficit, seizures or visual disturbance.
e. Different pattern of headache.
f. Trauma.
g. Headache triggered by cough or valsava (suggestive of raised intracranial pressure).

7.

Consider non-pharmacological strategies as first line treatment for migraine – such as good sleep hygiene and avoidance of screens.

8.

Paracetamol can be used in pregnancy, as can NSAIDS but only up to the third trimester. Avoid opioids if possible, in pregnancy as they can induce a headache and worsen nausea and vomiting.

9.

Antiemetics such as Metoclopramide, Cyclizine and Ondansetron can be used, as can Triptans in pregnancy such as Sumatriptan or Zolmitriptan.

10.

Those with severe migraine on multiple medications, such as topiramate or sodium valproate, need pre-pregnancy counselling to ensure they have good control of their symptoms and are on medication that is safe for use in pregnancy.

This guidance was correct at the time of publication. The PCWHF will undertake annual reviews of this guidance to ensure it remains in line with best practice. The next review is due in November 2026. The guidance is for use by healthcare professionals only. DOP: November 2023. For further information, please contact: enquiries@pcwhf.co.uk