Episode 209: What You Need to Know About Migraine During Pregnancy

Lindsay Weitzel, PhD:
Hello and welcome to HeadWise, the videocast and podcast of the National Headache Foundation. I'm Dr. Lindsay Weitzel. I'm the founder of Migraine Nation, and I have a history of chronic and daily migraine that began at the age of four. I am super excited to be here today with Dr. Susan Hutchinson. Hello, Dr. Hutchinson, how are you?

Susan Hutchinson, MD:
Hello. It's a pleasure to be here.

Lindsay Weitzel, PhD:
Dr. Hutchinson is our guest today because we are going to talk about pregnancy and migraine. We're going to delve really deep into the things that we can and maybe we shouldn't do while we're pregnant, trying to get pregnant, etc. And Dr. Hutchinson is a headache specialist and the founder of the Orange County Migraine and Headache Center in Irvine, California. She is very much sought after for her knowledge related to women and headache medicine. And I'm excited that she's our guest today because we really want the details on this. I know what it feels like to have a pretty severe migraine history and be wondering exactly what to do while I'm trying to get pregnant, while I am pregnant. It can be a little bit of a scary time, and so we want to give all the information we can on this topic. Dr. Hutchinson, I wanted to give you a chance to tell our audience a little bit about yourself and why you work in headache medicine.

Susan Hutchinson, MD:
Thank you, Lindsay, and thank you for having me. My background is actually family medicine, but in my 30s, I began getting these disabling headaches that I thought were just bad tension or stress headaches. But they were so bad I would have to go into one of my exam rooms, turn off the lights at lunchtime, take something for the nausea, something for the pain. And it was only about maybe a year later, I discovered that what I thought were stress or tension headaches were actually migraine. So, I have a personal experience with migraine. I know how disabling they can be. But in addition to that, even when I did family medicine, I always saw a lot of women in my practice.

And Lindsay, sometimes I found that if they had migraine, they were afraid to get pregnant. Because they were afraid, gosh, I have migraine, what's going to happen. And that really did become a passion for me. And then I actually worked with an OB group for about eight years, so I would see some of the patients that were pregnant. The OBs wanted me to help manage their headaches, so that really encouraged me to really try to stay up to date with what we know and what's safe, and to really encourage women, if you have migraines don't be afraid to get pregnant.

Lindsay Weitzel, PhD:
So honestly, I'd like to begin, if we can, by discussing why this topic is so important other than we are important. Our health matters. Our ability to work and function for ourselves and our families matters. But what are the dangers of allowing our migraine disease to go uncontrolled during pregnancy?

Susan Hutchinson, MD:
Well, first of all, I don't think it has to go uncontrolled. And to kind of put things in perspective, the majority of women have migraine without aura. About 87% of women that have migraine without aura, your migraines will get better. And they might even go in remission during pregnancy. Because we know Lindsay, during pregnancy your estrogen goes up. And guess what? It stays high and it stays fairly constant by the second and third trimester. So, I've actually had some women, believe it or not, tell me, Dr. Hutchinson, I wish I could always be pregnant.

So first of all, many listeners, your migraines are going to go away or get better. And if you have migraine with aura, a little bit less chance they'll get better. But the good news that we're going to talk about today is there are many both acute and preventive treatments. Some are prescription, some are not prescription. But there's really a lot we can do so the women who have migraine and are pregnant can still have a good quality life.

Lindsay Weitzel, PhD:
I think it's a hard decision to make. And I have to admit, I had two pregnancies, one of my pregnancies I got worse and one I got better. So, I don't know what to say. But I think be brave. And we're going to talk about some of the things that we can do. We do need to start with a little bit of background. Can you please explain how the FDA historically categorized medications when it came to pregnancy? This used to be how we talked about medicines.

Susan Hutchinson, MD:
Yes. There used to be a category rating that I think some physicians actually still use. And it was A, B, C, D and X. And it kind of made it a little too easy. But A and B were found to be safe. C was felt to be, well this is a medication that we need to weigh the risk versus the benefit. But D and X, I'll give you a couple examples. Some examples of X would be things like Cafergot, the ergot alkaloids, which are kind of an older category. But things like Depakote, they were thought, you know what, there's too much risk for the baby and the pregnancy. So, X is what you really stayed away from.

But what happened is the FDA said, you know what, there's evidence that continues to change. There's pregnancy registries that change. We need to have a more fluid way, a more accurate up to date way of looking at these categories. So actually, the FDA in 2015, they said we're going to have a new system. And we're just going to basically make comments depending on the level of evidence, what are we finding out in clinical trials in the pregnancy registries. So, the bottom line, it's not quite as easy anymore as A, B, C, D, and X.

Lindsay Weitzel, PhD:
Let's begin by listing the things that we all know you can take during pregnancy, if they're helpful for your migraine symptoms. These are going to include things that I'm just going to list it off and then let you comment. These things will include Tylenol, triptans, obviously nerve blocks, metoclopramide which is also known as Reglan, prochlorperazine which is Compazine, and diphenhydramine which is Benadryl. If you can comment on these things, because I'm going to go ahead and say a lot of these

things are not things that most of us are taking for migraine when we're not pregnant. So, it might be interesting for people to hear about them.

Susan Hutchinson, MD:
Good question. Well, first of all, the triptans really have proven themselves, I think, to be quite safe during pregnancy. The ones that have been most studied would be sumatriptan which is Imitrex, naratriptan which is Amerge, and rizatriptan which is Maxalt. But you're right. Some of the anti-nausea medications, with the exception of Zofran, some of the other ones, we don't normally continue to think of during pregnancy and even for migraine. But things like promethazine which is Phenergan, Compazine, metoclopramide which is Reglan, those actually are not just for nausea. They can actually help migraine, which is pretty amazing. Now keep in mind some can cause a little bit of sedation, but some women like to sleep off their migraine. And you had also mentioned diphenhydramine, which is Benadryl, which we often don't think about for regular migraine.

But the nice thing is these are now felt safe for pregnancy. So, the more complete you can have that toolbox because it might be a combination of things. If you had a bad headache, Lindsay, maybe you could take your triptan and you could take one of the anti-nauseas like metoclopramide and you could take the Benadryl. So, sometimes that cocktail or combining things that are felt to be safe can be really beneficial for a bad migraine attack during pregnancy.

Lindsay Weitzel, PhD:
I'm going to ask you some questions that I bet are running through women's mind right now, because a lot of us are only given Compazine IV when we've had a really severe migraine for over 72 hours. Is Compazine something that you can take orally during pregnancy?

Susan Hutchinson, MD:
Yes, Compazine, in fact, most of these antiemetics, including Reglan and Phenergan, it's not just a matter of IV or oral. Some of them even have themselves as a rectal suppository. So, for example, I've had women rescue with, whether or not they were pregnant, with a Phenergan, also known as promethazine, rectal suppository. That can be quite effective. And Reglan again, which is metoclopramide, is widely used both IV, IM, intramuscular, and orally. So, keep in mind some of these medications have multiple routes of delivery, and depending on how bad the migraine is can determine which route of delivery is most appropriate.

Lindsay Weitzel, PhD:
And then I'm going to ask a question about Benadryl. I was actually present once when a doctor was telling someone that yes, they can take Benadryl, but it's not going to help their migraine. It's just going to make them sleepy, so they sleep it off. But you feel that it's actually going to help the migraine and that they can take it during pregnancy.

Susan Hutchinson, MD:
I absolutely do. And in fact, Benadryl is actually used IV to rescue, let's say, a status migrainosus where a person's been suffering for over 72 hours, and that's whether or not they're pregnant. So, Benadryl

has some properties, I believe it's called antidopaminergic. But the point is, it is more than just an antihistamine or a sedative. It truly can help migraine.

Lindsay Weitzel, PhD:
I think that's important for people to know when it's one of the safe things they can take during pregnancy, is that it might actually help them not just make them sleepy. And then, this is a question that one time when we spoke about triptans during pregnancy, someone wrote in just to clarify. Are all routes of triptans delivery considered safe during pregnancy whether they be injections or nose spray, etc.?

Susan Hutchinson, MD:
Yes, I believe they're all safe. And what you want to do is prioritize. And if you have a really severe migraine or you're nauseated or vomiting, do the non-oral route of delivery, whether it be the injection or the nasal delivery. But I really, truly feel Lindsay, there's enough evidence now that whatever triptan a woman is taking prior to pregnancy, that can be the triptan she can use to take while she's pregnant. But again, most women, they're going to get better and they're not going to need as much of that acute medication.

Lindsay Weitzel, PhD:
This is all great news. I have a very important question that always comes up when it comes to ibuprofen. Some of us often take 800mg or so of ibuprofen with other medications at the onset of migraine. We can take it during pregnancy, but only during the second trimester. Is that correct?

Susan Hutchinson, MD:
That is correct. In fact, sometimes it's easier to say just avoid anti-inflammatories or what we call nonsteroidals throughout pregnancy. That's usually what I do. The problem with the first trimester is the nonsteroidals can interfere with the actual implantation and the conception. After 30 weeks, they can interfere or cause premature closure of something called the patent ductus arteriosus, also known as the PDA. So, there's that window of the second trimester where you probably could take your nonsteroidal.

Lindsay Weitzel, PhD:
What about things like Toradol?

Susan Hutchinson, MD:
Well, Toradol unfortunately is an NSAID. It also is in that category of nonsteroidal. That's why when you think about analgesics, if you want to use that term, that's why acetaminophen, which is Tylenol, with or without a little bit of caffeine, that's really probably the first line option for at least mild to moderate migraine during pregnancy.

Lindsay Weitzel, PhD:
Now we have a lot of newer medicines out that maybe the last time we discussed pregnancy on the podcast weren't available. I'm going to jump ahead to lasmiditan or Reyvow. In case we have anyone listening, I want to make sure we address, if this is your favorite medicine and you're wondering if you can keep taking it if you get pregnant. So, we're going to talk about lasmiditan, which does have that warning because it can make some people sleepy. Do we know anything about lasmiditan during pregnancy?

Susan Hutchinson, MD:
That's a great question. I believe it came out in 2020 just when Covid hit. And so, when you think about it, it's only been around since 2020 and you really need to get enough numbers reported in these pregnancy registries to actually make what I would call significant comment. And we just don't have enough numbers.

So, I would encourage a woman if you really like lasmiditan, and you are being allowed to still take it by your OB or your treating provider, please report it to the pregnancy registry. That's the only way we're going to find out. Lasmiditan is an example of a category called a ditan. It's not a triptan and so it's unique. And so, at this time Lindsay, we just don't have enough numbers in the pregnancy registry to make any definitive conclusion.

Lindsay Weitzel, PhD:
This is going to be a big one, because so many people are on it. Everyone wants to know about Botox and pregnancy, because stopping Botox can be really difficult if you have chronic migraine. So first of all, there is a Botox pregnancy registry. What have we found out from this registry?

Susan Hutchinson, MD:
Well, the good news is in the Botox pregnancy registry, it is very, very reassuring. And that's good because most of us that are headache clinicians, we are quite comfortable with Botox administration during pregnancy. You may wonder well why. Well, it doesn't get into your systemic circulation. It's not getting into the blood. It’s not going to the uterus and the placenta. Botox is injected with a small needle, but they're intramuscular, but they're very superficial. And so you're really treating the nerves. You're going into the muscles around where the nerves are that cause migraine.

So having said that, most women are going to get better during pregnancy. So, if a woman was on Botox but she got pregnant, I'd probably say don't come right back in for your next Botox because your migraines might get better. But if they don't, and all of a sudden, let's say she didn't come in at the 12-week mark, because Botox is done every 12 weeks, then I would be comfortable having her come in. But some women, they won't need it during pregnancy. But I will tell you when you go to any headache meeting, almost all headache clinicians have now gotten very comfortable with administering Botox during pregnancy.

Lindsay Weitzel, PhD:
That's great advice, by the way. Waiting and seeing how you feel, because you just never know. I was surprised by both my pregnancies, and how I felt. So, you just never know.

We're going to move on to the CGRP monoclonal antibodies. This would include things like Aimovig, Ajovy, Emgality, Vyepti. We do have a pregnancy registry for this. It's called GENESIS. I'd love to hear what we've learned so far about these. And then if you could tell us how long it is recommended that we perhaps stop taking these medications before we choose to become pregnant.

Susan Hutchinson, MD:
We're still trying to get information. For example, the GENESIS registry is specifically with Aimovig. But each company would have their own registry. And again, it takes a large number of women to really make definitive conclusions. Because the big question is, is blocking CGRP, is that going to be a negative for the fetus. And I'll be honest, I don't think we completely know.

But here's what we do know, is these injectables and the IV Vyepti, their half-life is 27 to 31 days. That means at that 27 to 31 day mark, you have 50% left of the drug still in your system. Complete elimination of any medication is five half-lives. So, if you do the math in your head, that means it's going to take about 5 months to have these completely out of your system. So, I usually recommend women stop if they're on Aimovig, Ajovy, Emgality, or IV Vyepti. Ideally stop at 5 to 6 months before you're actively trying to get pregnant. That's the safest. I think that's the most conservative route to take.

But let me just add, there is an oral gepant called Qulipta that can be taken once a day for prevention of episodic or chronic migraine. And guess what? It's half-life is only 11 hours, complete elimination 55 hours. So, a lot of times Lindsay what I'll do, is if a woman is doing really well on her CGRP monoclonal antibody injection, I will switch to Qulipta. Because I'm a lot safer about something with a 55 hour half-life that I can very quickly stop when she gets pregnant.

Lindsay Weitzel, PhD:
I'm so glad you said that. So basically, what you had said is if someone's stable on one of the injectable or IV monoclonals, maybe switch to Qulipta, which you could technically take until you become pregnant.

Susan Hutchinson, MD:
Yes. I would be very comfortable. And then when she got pregnant, I would have her stop it and again monitor the headache pattern, because she may not need to continue to take it. Because I just love the fact that about 87% of women who have migraine without aura, their migraines are going to either get much better or go on to remission during pregnancy.

Lindsay Weitzel, PhD:
Since we did talk about that one gepant Qulipta, do you have any comments about what we know about the other gepants in case women are taking those and wondering, like Ubrelvy or Nurtec.

Susan Hutchinson, MD:
Yeah. Great question. We're starting to look at both Ubrelvy and Nurtec, not just during pregnancy , but during breastfeeding. And again, the results are looking very promising. But again, these medications have only been out in recent years. They didn't really start coming out until 2020. So again, this is only 2024.

So, I guess my comment is I would be okay with a woman taking a gepant until she got pregnant. When she got pregnant, I think I would switch to some of the other options we talked about, like the triptans, like the metoclopramide, the diphenhydramine which is Benadryl. I just think there's a lot more things that we know more about because they've been around longer. We've had more time to look at the studies and the pregnancy registries.

Lindsay Weitzel, PhD:
Now let's back up from medications really quick to mention the preventive supplements that we know are safe in pregnancy for migraine, so women know they can take those and what are the dosages.

Susan Hutchinson, MD:
The two that are consistently felt to have enough evidence to be safe during pregnancy are B2, which is riboflavin, about 200mg twice a day, and magnesium, about 200mg twice a day. What's not recommended, because we don't have enough information, would be things like CoQ10. Some women take feverfew which I believe is in MigreLief and some of the supplements. So be careful on those over-the-counter migraines supplements that have more than one ingredient. I think the safest way to go is just B2 and magnesium.

Lindsay Weitzel, PhD:
The next question I have is for anyone who's listening who perhaps we haven't listed their medication that they feel they very much need for their migraine prevention, etc., whether it be Topamax or I don't know what we haven't listed so far. There could be a few things. And who do they go to? What is the best route to ask some of these really detailed questions? This is why I need this. This is the severe symptoms I had without it. What is the route and the types of specialists to go talk to when you really want to get pregnant, and you've got some intricate details to discuss?

Susan Hutchinson, MD:
Yeah, that's a great question. I think for any woman who has significant medical issues, whether it be migraine, whether it be epilepsy, whatever the issue is, there is a type of I'll be called a high-risk OB. And sometimes they work with the regular OB because some high-risk OBs don't do routine deliveries. They work with the regular OBs to do things like talk about medication, what do we know. And I find, Lindsay, that the high-risk OBs are a lot more comfortable sometimes with medications if the regular OB is not.

Now in another instance, maybe some of your listeners have a wonderful headache physician. For example, if someone was here in California to see me, I'd be happy to work with their OB because I feel very comfortable on what I'm doing. I think what's really sad and I just encourage your women, if you have an OB that says don't take anything but Tylenol and you're really struggling, you need to push that

OB and see if they'll refer you to a high-risk OB or a headache specialist. Because you deserve to have good treatment and not suffer with severe migraines during pregnancy.

Lindsay Weitzel, PhD:
Thank you so much for this awesome information, Dr. Hutchinson. This was a great, great episode. Is there anything else you'd like to add before we go?

Susan Hutchinson, MD:
Again, I just want to add, if you're listening and you're worried about what's going to happen during pregnancy, please know again that the majority of you, your migraines are going to get better during pregnancy. You might even go into remission. But if you still get migraines, there are wonderful treatment options that can still help you.

Lindsay Weitzel, PhD:
Great. All right, well, I hope everyone enjoyed this episode and was able to take away something informative. Please join us again on our next episode of HeadWise. Thank you again. Bye bye.