Getting to the Heart of the Matter: Hypertension and Pregnancy among the Black Community

My baby sister was 35 years old and pregnant with her first child. As a family, we were ecstatic. The family was expanding, and I was about to be an aunt for the third time. She was in her 3rd trimester and very pregnant, but she was up there in the choir singing and dancing her heart out at a memorial concert. I, along with many others, was shocked at how energetic and agile she was that far into pregnancy. However, when the concert was over, I looked at her feet and they were very, very swollen. I was concerned and told her to speak with her doctor immediately. Three days later, she got a call from her doctor to check in to the hospital, 6 days before her actual due date. Unbeknownst to me, she had dropped off a urine sample the day before the concert. Test results revealed that she had preeclampsia (a type of high blood pressure that is specific to pregnancy) and they needed to deliver the baby. Left untreated, preeclampsia can be very dangerous for mom and baby. My sister scrambled to get everything together and rushed to the hospital, and baby Jordan, my nephew, was born. My sister is a strong, educated, physically fit African American woman, and thank God her story ended well. However, that is not always the case. It could have gone a very different way.

Hypertensive disorders of pregnancy (HDP) are a group of medical conditions that involve high blood pressure during pregnancy. High blood pressure, also known as hypertension, is a condition where the force of the blood against the walls of the arteries is too high. This can damage the arteries and increase the risk of heart attack, stroke, and other serious health problems. Hypertensive disorders of pregnancy are a leading cause of maternal death and can put both mother and baby at risk for serious complications during pregnancy.

There are four main types of hypertensive disorders of pregnancy:

- **Chronic hypertension**: High blood pressure that occurs before pregnancy or before 20 weeks of gestation, or that persists longer than 12 weeks after delivery.
- **Gestational hypertension**: High blood pressure that develops after 20 weeks of gestation, without signs of organ damage or protein in the urine.
- **Preeclampsia**: High blood pressure that develops after 20 weeks of gestation, with signs of organ damage or protein in the urine.
- **Preeclampsia superimposed on chronic hypertension**: Chronic hypertension that worsens or causes organ damage or protein in the urine during pregnancy. This means that you have two problems with your blood pressure.

Chronic hypertension affects approximately 85,000 births (2.3%) in the United States each year. Unfortunately, the number of pregnant women diagnosed with HDP is increasing and more maternal deaths are occurring due to complications from these conditions in pregnancy. On top of that, the rates between white people and other racial groups are widening, especially among black pregnant women during pregnancy. According to a Centers for Disease Control and Prevention (CDC) report, HDP affected at least 1 in 7 delivery hospitalizations in the United States from 2017 to 2019, and about a third of those who died during hospital delivery had some form of HDP. Some of the other key findings of the report were that:

- HDP affected more than 1 in 5 delivery hospitalizations of Black women and about 1 in 6 delivery hospitalizations of American Indian and Alaska Native women, compared to 1 in 8 delivery hospitalizations of White women.
- Black women had higher odds of entering pregnancy with chronic hypertension and developing severe preeclampsia.
- Black women and American Indian and Alaska Native women had higher rates of maternal death due to HDP than White women.

The causes of hypertensive disorders of pregnancy are not fully understood, but some risk factors include obesity, diabetes, kidney disease, family history, multiple pregnancies, and advanced maternal age (over age 35) and the rates are higher among communities of color compared to white people. In general, more than 50% of black women have hypertension, compared to 39% of non-Hispanic white women and 38% of Hispanic women. The symptoms of hypertensive disorders of pregnancy may vary depending on the type and severity, but some common ones are headaches, swelling, blurred vision, stomach pain, and reduced amounts of urine than usual.

HDP can be dangerous for both you and your baby, but it can be prevented and treated with proper care and attention. To reduce the chance of HDP, pregnant women and those planning for pregnancy can take the following steps:

- Get early and regular prenatal care. They can check your blood pressure and screen for any signs of HDP[1].
- Take your blood pressure medication to lower your blood pressure and prevent complications. They may also advise you to take a low-dose daily aspirin after 12 weeks of pregnancy to reduce the risk of preeclampsia[2].
- Maintain a healthy weight and lifestyle. Try to lose weight before you conceive and gain weight gradually during pregnancy according to your doctor's guidelines. Exercise regularly, eat a balanced diet, avoid smoking, limit alcohol and salt intake, and manage stress[23].
- Monitor your blood pressure at home. Your doctor may suggest that you use a home blood pressure monitor to keep track of your blood pressure between visits.

MotherToBaby has helpful fact sheets on smoking, alcohol, stress and exercise, and low-dose aspirin. You can also contact us for information on medications that may be recommended by your healthcare provider for treatment. We are a free service that is available for everyone. The heart of the matter is that you do what is best for you and your baby and we are here to help you through all stages of pregnancy from the time you hear a heartbeat on a monitor and until the time your baby captures your heart.

Resources:

American Heart Association. (2023, February 27. Black women of childbearing age more likely to have high blood pressure, raising pregnancy risks. Accessed February 7, 2024 Read More

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Getting to the Heart of the Matter: Hypertension and Pregnancy among the Black Community

Dealing with constipation can be challenging, and the struggle intensifies during pregnancy. The struggle is real, and I know it firsthand! I have struggled with constipation ever since I was a teenager. But once I started college, the stress of my day-to-day life intensified my symptoms which led me to suffer from chronic constipation. Once I found out I was pregnant, I knew it was only a matter of time until I experienced the discomfort, pain, and bloating all over again. But I knew that, while this might be disheartening, I was not alone. Up to 38% of pregnant individuals experience constipation in the first trimester (***Trottier et al., 2012***).

This common issue has even earned its own ICD-10 code (used for medical billing), emphasizing the need for attention and solutions. Let's explore the reasons behind pregnancy-related constipation and discover effective ways to manage and alleviate it. Our Constipation Resource Hub is a great way to access all the information that MotherToBaby experts have for you related to this topic, but let's go over some specifics first!

Understanding the Causes of Constipation in Pregnancy:

Constipation during pregnancy can be attributed to various factors, including an unbalanced diet, insufficient fiber intake, inadequate hydration, and a lack of physical activity. Hormonal changes, particularly an increase in progesterone, also play a significant role. Additionally, medications used to combat nausea and vomiting in pregnancy (NVP) and supplements like iron and calcium may contribute to constipation.

Navigating Treatment Options during Pregnancy:

While constipation is common during pregnancy, suffering needlessly is not acceptable. Explore different treatment options, but keep in mind that there is no one-size-fits-all approach. Understanding the complexities of your individual situation is crucial.

Nutrition Adjustments:

- Incorporate 4-5 cups of fresh fruits and vegetables daily.
    - Aim for 25-30 grams of fiber daily.
    - Stay hydrated by drinking plenty of water.
    - Engage in 150 minutes of moderate exercise per week (consult your healthcare provider before starting any new exercise routine during pregnancy).

Medication Considerations:

- Laxatives can be an option, they are medications used to soften stool or stimulate the bowel, but it's essential to be informed. Explore our fact sheet on laxatives here https://mothertobaby.org/fact-sheets/laxatives/. Here's a brief run-down of some of these options:

- Bulk-forming laxatives (fiber supplements) like psyllium
    - Osmotic laxatives
    - Stool softener laxatives
    - Stimulants, and lubricants

Prescription medications

- Prucalopride (Motegrity®) for the treatment of functional constipation, also known as chronic idiopathic constipation. Read our fact sheet here.

Managing Underlying Conditions that May Make Constipation during

Pregnancy Worse:

Some individuals may face constipation due to underlying conditions such as Irritable Bowel Syndrome (IBS-C) or **Functional Constipation** (FC). Consult your healthcare provider for a proper diagnosis and follow their recommendations. Explore our informative fact sheet on Functional Constipation here. https://mothertobaby.org/fact-sheets/functional-constipation/ .

Stress can exacerbate constipation, especially for those with IBS-C. Be kind to yourself and explore stress management techniques. Learn more about stress during pregnancy in our fact sheet here https://mothertobaby.org/fact-sheets/stress-pregnancy/ .

For those with **Gestational Diabetes** or a predisposition to Type 2 Diabetes Mellitus, regulating blood glucose levels is crucial. Explore our blog on diabetes during pregnancy here https://mothertobaby.org/baby-blog/diabetes-and-pregnancy-the-not-so-sweet-story/ .

In conclusion, constipation during pregnancy is a shared experience, but it shouldn't be endured without seeking relief. I certainly looked for options that helped me during my pregnancy, just like I did, so can you! Open a conversation with your healthcare provider to explore solutions. By making dietary adjustments, staying active, and managing stress, you can navigate constipation more comfortably during this transformative time. For personalized information about medications or conditions, or to volunteer for the **study on constipation** (https://mothertobaby.org/ongoing-study/constipation/) in pregnancy, reach out to our experts at MotherToBaby—they're here to answer your questions and provide support throughout your pregnancy journey.

We want to enroll all individuals who took Motegrity® at any point in their current pregnancy or while breastfeeding. If you, or someone you know has been exposed to this medication, please report use to our team.

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Getting to the Heart of the Matter: Hypertension and Pregnancy among the Black Community

By: Kirstie Perrotta, MPH and Becky Spencer, PhD, APRN, PMHNP-BC, IBCLC, PMH-C, FILCA

Shannon was newly pregnant and had been referred to MotherToBaby by her doctor. She was taking 50 mg of sertraline per day for general anxiety and her doctor thought that she may need to wean off the medication now that she was 5 weeks pregnant. Shannon had been taking the medication for 3 years and was feeling great on her current dose, so she had some concerns about this plan. On the MotherToBaby website's live chat service, Shannon was connected with me, a teratogen information specialist, where she asked "Do I really need to stop my anxiety medication, or could I just continue on a lower dose?"

I started by addressing the importance of weighing the risks vs. benefits of taking any mental health medication during pregnancy. Sertraline is very well studied and has not been associated with a risk for birth defects, but does have the potential to cause neonatal adaptation syndrome or withdrawal approximately 10-30% of the time and persistent pulmonary hypertension in less than 1% of exposed infants. On the other hand, we know that untreated anxiety can also cause problems for the pregnancy, including an increased risk for preterm delivery. For many patients, the benefits of staying on a medication like sertraline outweigh the potential risks, but each case is unique and ultimately the patient needs to decide what they are most comfortable with.

Getting to Shannon's next question about dose, I shared that although many pregnant women feel they need to decrease their dose once they get a positive pregnancy test, the opposite is in fact true. During pregnancy, there are many changes that occur including weight gain, increased blood volume and enlargement of the kidneys. On the outside, things won't look much different, but research shows these changes happen soon after conception. This means that medication doses that previously worked well to control a condition become "diluted," in a sense, and may not be as effective. In some cases, women need to actually increase their dose to continue to control the disease.

To learn more about how bodily changes during pregnancy impact medication dosing, we turn to Becky Spencer, PhD, APRN, PMHNP-BC, IBCLC, PMH-C, a psychiatric nurse practitioner who specializes in perinatal mental health at Texas Women's University with some more questions about this fascinating phenomenon.

Q. Can you tell us a little more about what is happening in the body during pregnancy and why medications become less effective?

Becky Spencer: You are correct, Kirstie, that pregnancy has a significant impact on drug absorption, which is how a drug is transported into the bloodstream, drug distribution, which is the disbursement of a drug as it moves through the blood and tissues of the body, and drug metabolism, which is the process by which the body breaks down and eliminates drugs or other substances. During pregnancy, especially later in pregnancy, drug absorption from the

stomach into the bloodstream is decreased due to slower gastric emptying and slower movement of the bowel and colon, so it can take longer for a medication to be absorbed and get to work.

A pregnant woman's blood volume almost doubles during pregnancy which impacts drug distribution. With the dilution effect there is a lower concentration of medication in the blood plasma which results in less medication reaching the target tissues. Most drugs are metabolized in the liver or kidneys. During pregnancy, the increased blood flow to the kidneys results in an increased glomerular filtration rate (GFR), which means that medications are cleared from the bloodstream quicker, meaning the drug stays in the body less time. Similarly, hormone levels increase during pregnancy which increases the activity of various metabolic enzymes in the liver that metabolize drugs. When the liver metabolizes a drug more quickly there is less drug that reaches the target tissues.

What these changes mean for pregnant women who take medication for mood and anxiety disorders is that the dose of medication that they were taking before pregnancy may have a decreased effect during pregnancy, because the biological changes effectively decrease the amount of medication reaching the target tissues, in this case, the brain. Pregnant women may have an increase in mood and anxiety symptoms that they interpret as a worsening condition when, in fact, the decrease in circulating medication is the cause for an increase in symptoms.

Q. In your practice, how often do you see women increasing their mood medication dose? Does the dose need to be increased substantially?

Becky Spencer: That is a great question. The answer is that it depends on the type of medication, the specific condition (depression, anxiety, obsessive compulsive disorder, bipolar, etc.), and the severity of symptoms. Psychiatric providers typically increase medication dosages in gradual amounts until the patient has symptom relief or desired therapeutic effect. If a patient is experiencing a partial response to a medication (some improvement in mood and anxiety symptoms) best practice is to increase the dose of that medication before considering adding an additional medication.

Another question that I hear is whether or not dosages of medication should be based on achieving a specific blood plasma concentration level. The short answer is, for most medications, no. We don't routinely check blood plasma concentrations of most antidepressants because valid and reliable therapeutic plasma concentration ranges do not exist. Some mood stabilizing medications like valproate or lithium do require blood plasma monitoring both during pregnancy and outside of pregnancy. Euthymia, or stable mood, is the goal of medication dose adjustments for mood and anxiety disorders during pregnancy.

Q. What about after delivery? Does the dose need to be decreased right away?

Becky Spencer: It depends on the type of medication, and, to some extent, the symptoms that the patient is experiencing. The postpartum period is a vulnerable time for mood and anxiety disorders for several reasons including the significant hormonal shift that occurs after birth, lack of sleep, role adjustment to caring for a baby, and for some new parents, lack of necessary social and emotional support. Decreasing antidepressants too quickly after birth could exacerbate mood and anxiety symptoms during that very vulnerable time. The decision to decrease dosages of any medication prescribed for mood and anxiety disorders should be a collaborative decision between the patient and the provider. If decreasing mediation dose is desirable, it should occur gradually and any change in mood and anxiety symptoms should be reported to the provider. The one exception to this rule is for patients taking lithium. If lithium dosages were increased during pregnancy, they must be decreased to pre-pregnancy dosages after delivery.

Q. Shannon is asking about sertraline, an anti-anxiety medication, but are there other drugs that women

need to also increase their dose of during pregnancy?

Becky Spencer: Any medications used to treat mood and anxiety disorders, including antidepressants, mood stabilizers, antipsychotics, and anti-anxiety medications, may need dose increases during pregnancy. The most important point is for pregnant women to monitor their mood and anxiety symptoms and report them to their provider. The decision to increase doses of medication should always be a collaborative decision between the patient and the healthcare prescriber.

Q. How should patients approach this conversation with their healthcare provider?

Becky Spencer: The decision to take any medication during pregnancy must be based on a discussion between healthcare providers and patients that takes into consideration the available research on the risks of specific medications AND the risks of untreated or undertreated mental conditions for both the pregnant woman and the baby. The risks of not treating mood and anxiety disorders during pregnancy are well documented and significant. Untreated or undertreated mood and anxiety disorders during pregnancy are associated with hypertension, preterm delivery, low birth weight, and long-term negative impacts on motor and cognitive development of the baby. Mental health conditions are the leading cause of maternal mortality in the United States. Effective treatment for mood and anxiety disorders in the perinatal period will literally save lives.

My top three tips for having a discussion with healthcare providers about medications for mood and anxiety disorders in the perinatal period include:

- Make an appointment with a psychiatric provider who specializes in perinatal mood and anxiety disorders or reproductive psychiatry. The provider directory on the Postpartum Support International website is a great place to find specialists in your state, and many provide telehealth services.

- If your obstetric provider is hesitant to treat your mood and anxiety symptoms, recommend that they make an appointment to speak with a psychiatric provider who specializes in treatment of perinatal mood and anxiety disorders during pregnancy at the Postpartum Support International Psychiatric Consult Line. This free service is staffed by perinatal psychiatrists who are available to share their skills and expertise and provide guidance to fellow medical professionals on prescribing medications during pregnancy and lactation.

- MotherToBaby Fact Sheets are an excellent resource and a great way to start a conversation with your provider about specific medications for mental health during pregnancy and lactation. I recommend that pregnant and lactating women who are taking medications for mood and anxiety disorders access and print out the MotherToBaby Fact Sheets for the medications that they are taking or are interested in learning more about, read them, jot down questions, and take them to their obstetric and/or psychiatric providers to start the

conversation. Remember that you are your own best advocate for you and your baby's health.

Thanks so much for sharing your insight, Becky. It's always great to learn more about this topic.

Ultimately, Shannon decided to stick with her current dose for the first few weeks of pregnancy and make an appointment with her psychiatrist to discuss increasing her dose in a few weeks. In the meantime, she was planning to monitor her mood to make sure the anxiety remained well controlled.

If you have questions about mental health medications, dose, or any other exposures in pregnancy or lactation, please feel free to reach out to a MotherToBaby specialist via phone, chat, text, or email for more information. Additionally, you can visit our Mental Health Resource Hub to access fact sheets, blogs, and podcasts on mental health conditions and the medications used to treat them during pregnancy and breastfeeding.

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Getting to the Heart of the Matter:

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- My fear and anxiety over my soon-to-arrive first child is overwhelming on a daily basis…I'm angry some days, sad some days, and panicked other days.
- My anxiety and depression levels has been higher than normal
- I'm scared when I go anywhere or see anyone, even when I'm maintaining social distancing.
- We planned on having an amazing support team and the rug was pulled from under us.
- I realize this is uncharted territory, but I have not felt supported as a first-time mother.[1]

These were the sentiments of pregnant individuals going through the pandemic. It was an unprecedented event and as MotherToBaby Specialists we were challenged with dealing with the anxiety of expectant parents as they tried to get reliable information and deal with their fears, anxiety, and frustrations. Fortunately, as time went on, the infection did not appear to increase the chance of birth defects but now there is a question of the emotional toil it put on pregnant women.

Post-traumatic stress disorder (PTSD) is a condition of persistent mental and emotional stress that occurs after suffering a stressful or extremely traumatic event. Unlike post-traumatic stress that lessens over time, the symptoms of PTSD do not fade. Symptoms of PTSD fall into the following four categories and can vary in severity:

- **Intrusion**: may include intrusive thoughts or distressing memories, flashbacks, nightmares
- **Avoidance**: may include avoiding thinking or talking about the event or their feelings; avoiding things that remind them of the event (people, places, activities).
- **Negative changes in thinking or mood:** may include lack of memory on details about the event; negative thoughts and feelings about themselves or others; feeling numb or detached from others; loss of interest in activities.
- **Changes in physical and emotional reactions (arousal):** may include being irritable and having angry outbursts; self-destructive behavior; having problems concentrating or sleeping.

In general, PTSD occurs more often in women than in men and in the pregnant population more than non-pregnant individuals. According to some studies, 3% to 19% of pregnant women experience PTSD.[2] When it comes to psychiatric disorders during pregnancy, PTSD after childbirth or postpartum PTSD is considered the third most common mental health disorder after depression and nicotine dependence.[3]

If left untreated or poorly treated, PTSD can have long lasting effects not only for the pregnant woman but also in her relationships with other people, especially family, and interfere in bonding with their child and breastfeeding that can have long-lasting impact on the child. Pregnant women with untreated PTSD have a higher chance of experiencing negative birth outcomes including gestational diabetes (diabetes that develops during pregnancy), preeclampsia (severe high blood pressure), low birthweight (weight at birth of < 2500 grams,5.5 pounds), and preterm birth (before 37 weeks pregnancy). Also, quite alarming, PTSD is closely linked to attempting or committing suicide and substance abuse, two leading causes of maternal death in the United States.[3]

We know that the pandemic was a stressful situation for the entire country and especially pregnant women, but what were the long-term effects, particularly in regard to PTSD. In general, risk factors for postpartum PTSD include, but are not limited to, the fear of childbirth, prenatal health concerns (preeclampsia, birth defects), the lack of emotional/social support, depression and anxiety. During the pandemic the primary concern was the risk of infection for themselves and for their child before birth and after. Also, birth plans had to be changed due to hospital restrictions. They did not have the social support that they expected or planned with their doulas, partners, family or friends. The lack of social support was not only an issue during childbirth but remained after birth due to stay-at-home orders. Furthermore, expectant parents may have had to face other problems amplified by the pandemic like unemployment and the loss of a loved one. The sense of security and community was greatly affected during the pandemic and then expectant parents had to navigate a new world while just becoming parents, as expressed by pregnant women above. All of these factors can create a traumatic experience of childbirth and raise the chance for PTSD.

There have been multiple studies investigating the effects of the COVID-19 pandemic during pregnancy. While studies may have differed in their approach to review this topic, the results generally showed that giving birth during the pandemic had many effects on the pregnant population and that PTSD was quite common. Also, rates of PTSD were higher among Black and Latinx pregnant women than whites and lower socio-economic status (i.e., less educational and income).

Recommendations:

There is a call for PTSD to be screened during pregnancy and after to make sure that no one falls through the cracks. It is suggested that providers who had patients deliver in the early part of the pandemic, follow-up with them to make sure they are coping well. Not everyone who experiences PTSD will need counseling, but pregnant women should know about their options.

"Trauma is perhaps the most avoided, ignored, belittled, denied, misunderstood, and untreated cause of human suffering," said Peter Levine, PhD, trauma specialist. For pregnant individuals, if your symptoms are interfering with your quality of life, please speak with your healthcare professional so that you can get the assistance that you need. ***As MotherToBaby information specialists we can connect you to the resources that can promote your health and well-being. We provide information about medications used to treat PTSD as well as exposure to anxiety, depression, and stress on pregnancy and breastfeeding. We are just one important resource that new and expecting parents can rely on for confidential information. Contact us today or visit our Resource Hub on Mental Health during pregnancy and breastfeeding.***

There are resources available to help you.

Postpartum Support International: https://www.postpartum.net/learn-more/postpartum-post-traumatic-stress-disorder/

National Maternal Mental Health Hotline: **1-833-943-5746 (1-833-9-HELP4MOMS)**

https://mchb.hrsa.gov/national-maternal-mental-health-hotline

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"I can't get rid of it fast enough!" Caroline was 5 months pregnant and at her wits end when she contacted MotherToBaby. "My migraine is so bad that I can barely get out of bed, but I feel like there's nothing I can do about it since I'm pregnant. I don't want to harm the baby!" We often get questions like Caroline's from women planning a pregnancy or already pregnant who would like information on the prevention and treatment of migraine headaches, so I start by asking Caroline what she would have used if she weren't pregnant. Caroline told me that she would have taken ibuprofen and or sumatriptan.

Migraine preventions and treatments fall into three basic categories:

- **Over the counter remedies** such as aspirin or other NSAIDs, or acetaminophen with or without caffeine.
- **Prescription medications** such as opioids, various anticonvulsants, triptans, tricyclic antidepressants and beta blockers.
- **Alternative therapies** such as Botox or other nerve block injections, massage therapy, acupuncture, high doses of magnesium, or essential oils.

Most women have tried more than one therapy that has failed before they find one or a combination of products that will work for them. Migraines can be very debilitating, so the thought of having to go without a prevention or treatment that works can be very anxiety producing. Yes, it is true that some women find that their migraines disappear during pregnancy, but in others, they become more frequent. Having a plan for prevention and treatment, just in case, is necessary. We can help with the development of that plan by providing migraine sufferers with evidence-based information about the safety of various treatments during pregnancy (and also while breastfeeding!). Below is a brief summary of many common migraine medications and treatments, but we encourage you to visit our Fact Sheets or contact our experts for more detailed information.

Over the Counter Remedies

Typically, non-steroidal anti-inflammatory medications like aspirin, naproxen and ibuprofen are not recommended in pregnancy.

Acetaminophen alone does not always provide relief for a migraine, but its use should not be of great concern depending on how much or how often it is needed.

Caffeine can sometimes be added to enhance the relief of a migraine in some individuals. Typically, such doses of caffeine are not expected to create an increased chance for adverse pregnancy outcome. For further guidance on caffeine, see our fact sheet.

Other over the counter remedies that fall into the herbal or supplement categories are also not recommended since they are not well regulated or studied for safety. See our fact sheet on herbal supplements.

Prescription Medications

Many women find that over-the-counter products are not helpful enough and turn to healthcare providers for prescription medication relief. Prevention of the headache in the first place is key for some.

Beta blockers have been around a long time and used daily for migraine prevention in some individuals. Studies do not suggest that their use in pregnancy is high risk. See our Fact Sheets on metoprolol and propranolol for additional information.

The tricyclic antidepressants, such as amitriptyline and nortriptyline, are older drugs that have been successful in some at the prevention of migraine headaches when used daily. They too have not been found to be high risk products when used in pregnancy.

Other medications such as certain anticonvulsants have been used to prevent or reduce the severity or frequency of migraines. However, these medications have more complex concerns when used in pregnancy. The chance for complications in pregnancy must be individually and carefully weighed against the benefits of keeping migraines in check.

The “triptan” products were designed specifically to treat migraine headaches and include sumatriptan, rizatriptan, frovatriptan and naratriptan. As the “triptan” medication that has been around the longest time, sumatriptan has relatively reassuring data on use during pregnancy.

Opioids are used to treat the extreme pain caused by migraines. While they are not typically found to cause a significant increased chance for birth defects, regular use can create problems later in pregnancy or after birth. In some cases, their use may cause rebound headaches and therefore create more need for treatment.

Alternative Therapies

Migraines can be really difficult to prevent or treat, and some women turn to alternative therapies. Botox, bupivacaine, or lidocaine injections have been used as nerve blockers to treat migraines. However, it may not be best to try these out for the first time during a pregnancy.

Some non-pharmaceutical options include massage therapy and acupuncture. Your healthcare provider may be able to refer you to someone who has experience implementing these treatments with pregnant women.

Essential oils are used topically or in a diffuser. Be careful not to ingest any. If you are nursing or have an infant, be sure not to leave oils on your body where they might accidently ingest them.

We have had questions about the use of high doses of magnesium to curb migraines. We cannot recommend this option and suggest that you seek out the advice of your healthcare provider to determine if such treatment would be helpful or wise.

The Takeaway

I gave Caroline a summary of what is known about her usual migraine treatments, and suggested she have a conversation with her healthcare provider to discuss a safer alternative to ibuprofen and whether her provider would suggest any other changes to her treatment plan. The bottom-line is the benefits of some treatments may outweigh the risks of not treating migraines. A healthy mama from toe to head (especially a pain-free head) is best for baby too.

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