

Postpartum Headaches Go Unreported, Untreated

BY SHARON WORCESTER
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FORT MYERS, FLA. — The majority of postpartum headaches are primary headaches, and many go untreated, a large study suggests.

About 39% of 985 postpartum women in the prospective cohort study developed a postpartum headache. Primary headaches, such as tension or migraine headaches, were nearly 20 times more frequent than secondary headaches, such as postdural puncture headaches, Eric Goldszmidt, M.D., reported in a poster presentation at the annual meeting of the Society for Obstetric Anesthesia and Perinatology.

In fact, migraine and tension headaches accounted for about 73% of all headaches in the study, and musculoskeletal and cervicogenic headaches accounted for about 15%. Postdural puncture headaches accounted for only 4.5%, and the remaining headaches were of an undetermined type, said Dr. Goldszmidt, staff anesthetist at Mount Sinai Hospital, Ontario, and a lecturer at the University of Toronto.

Development of postpartum headache and/or neck and shoulder pain was evaluated via interview and chart review at 3 days and 1 week post partum, and patients were instructed to call if headache developed after that time.

Headache diagnosis was confirmed us-

ing an algorithm based on International Headache Society criteria, and risk factors for postpartum headache were identified. Women with known inadvertent dural puncture were at extremely high risk of postpartum headache (adjusted odds ratio 6.4), as were those with a history of headaches (adjusted odds ratio of 1.6 in those with 1-12 headaches per year, and 2.3 in those with more than 12 headaches per year), Dr. Goldszmidt said.

Age slightly increased headache risk with each year. Multiparity also was a significant risk factor for postpartum headache.

Most headaches in this study developed about 3 days after discharge, suggesting that many postpartum headaches might go unreported, untreated, and that the incidence of postpartum headaches is underestimated, he said in an interview.

"Postpartum headaches may be responsible for some discomfort and anxiety that is treatable," he said.

Of note, postdural puncture headaches accounted for only 21% of all headaches with postdural symptoms—particularly pain relief when supine, which has been considered diagnostic for postdural puncture headaches.

The high incidence of primary headaches with postdural symptoms may confound the diagnosis of postdural puncture headaches, he said. ■

5% Lidocaine Applied Nightly Effective for Vulvar Vestibulitis

BY PATRICE WENDLING
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CHICAGO — Long-term use of 5% lidocaine ointment shows promise as a treatment for the management of vulvar vestibulitis, vaginal apex pain, and intrinsic cervical pain, John Steege, M.D., said at a meeting sponsored by the International Pelvic Pain Society.

"We started out with vestibulitis pain and moved on to vaginal apex pain, and overnight lidocaine works pretty well," said Dr. Steege of the division of advanced laparoscopic and gynecologic surgery at the University of North Carolina, Chapel Hill. "We've done 52 vaginal apex revisions, but we've slowed down on that in the last few years because the overnight lidocaine works pretty well."

Dr. Steege credits colleague Dennis Zolnoun, M.D., of the department of ob.gyn. at the university, for the thinking behind the treatment. In a small study last year, Dr. Zolnoun and colleagues treated 61 women who presented with introital pain and met the criteria for vulvar vestibulitis.

After a mean of 7 weeks of nightly treatment with 5% lidocaine ointment, 76% of women reported the ability to have intercourse, compared with 36% before treatment. Intercourse-related pain score was 39 points on a 100-mm visual

analog scale after treatment, with a decrease of 10 points in daily pain score.

They found no association between the response to nightly treatment with lidocaine ointment and prior episodic use of lidocaine.

Dr. Steege said the treatment has evolved from a nightly application of lidocaine ointment to a three-times-daily application. Topical estrogen also is sometimes added.

Some patients with intrinsic cervical pain are treated with 5% lidocaine using a diaphragm. In these patients, "the cervix looks fine, but if you take a [cotton swab] and walk it around the cervix, at 3 o'clock it hurts; sometimes after deliveries, but sometimes it's plain out of the blue," Dr. Steege said. "Have them use a diaphragm with a little lidocaine jelly in it overnight and keep it anesthetized for 8 hours out of the day, and a fair amount get better. You're treating it like a neuropathic pain."

Dr. Steege said that changes in the last 20 years in the way pelvic pain is viewed, as well as cross talk between disciplines, have opened new avenues for the clinical treatment of pelvic pain. This includes using local anesthetics whenever possible together with physical therapy techniques and medications aimed at peripheral somatic changes and central changes, respectively. ■

DRUGS, PREGNANCY, AND LACTATION

Migraine Drugs

Migraine symptoms improve in up to 70% of women during pregnancy, usually during the second and third trimesters. But in 4%-8% of women, migraines worsen, and as many as 16% of all migraine cases during pregnancy may be new onset.

A 2002 review identified drugs or drug classes used for preventing migraine attacks (*N. Engl. J. Med.* 2002;346:257-70), including four drugs available in the United States that were considered well-accepted treatments or had proved to be effective: metoprolol, propranolol, amitriptyline, and valproate. Verapamil (Calan, Isoptin) and selective serotonin-reuptake inhibitors (SSRIs) were also widely used, but the reviewers concluded that there was poor evidence of benefit. Gabapentin (Neurontin) and topiramate (Topamax) were considered promising for migraine prophylaxis.

Of all these agents, only amitriptyline, verapamil, and low-dose propranolol (30-40 mg/day) have sufficient data to be classified as low risk throughout pregnancy. However, higher doses of propranolol may cause intrauterine growth retardation (IUGR) and other fetal/neonatal toxicity. Based on the drug class (antihistamine and calcium channel blocker), flunarizine is probably compatible with pregnancy. Gabapentin and topiramate should be avoided in the first trimester because of inadequate human data to assess their risk. Valproate is known to cause neural tube defects and other structural anomalies if used in the first trimester, and use of metoprolol during the second and third trimesters is associated with an increased risk of IUGR. Use of the SSRIs in the third trimester may cause newborn toxicity, and methysergide and other ergot alkaloids are contraindicated in pregnancy.

Numerous other drugs have been used in treating migraines, including acetaminophen (alone, or in combination with caffeine and butalbital, aspirin and caffeine, or isometheptene and dichloralphenazone); NSAIDs, including aspirin; chlorpromazine (Thorazine); dimenhydrinate (Dramamine); diphenhydramine (Benadryl); morphine; and meperidine. Others are dihydroergotamine (Migranal, D.H.E. 45), ergotamine (Ergomar) (alone or in combination with caffeine, or caffeine-belladonna-pentobarbital), intranasal lidocaine, and selective serotonin receptor agonists, also called triptans.

Combination products with butalbital are not recommended because in studies, the butalbital component did not increase efficacy. Acetaminophen, caffeine, dimenhydrinate, diphenhydramine, narcotic analgesics, and lido-

caine are compatible in pregnancy. However, frequent, prolonged use of narcotic analgesics may result in maternal and fetal addiction.

Depending upon the gestational stage of exposure, several therapeutic agents can cause developmental toxicity in humans. NSAIDs, including aspirin, have been associated with miscarriage when used around the time of conception, and exposure in the third trimester is associated with premature closure of the ductus arteriosus with

the risk of persistent pulmonary hypertension of the newborn.

Since aspirin causes irreversible inhibition of platelet function and other clotting disorders, its use near term may enhance maternal blood loss at delivery and increase the incidence of intracranial hemorrhage in premature or low-birth-weight infants. Ergot alkaloid preparations

are contraindicated in pregnancy because of their dose-related developmental toxicity and oxytocic properties.

Seven triptans indicated for the short-term treatment of migraine with or without aura are available: sumatriptan (Imitrex), almotriptan (Axert), eletriptan (Relpax), frovatriptan (Frova), naratriptan (Amerge), rizatriptan (Maxalt), and zolmitriptan (Zomig).

In animal studies at doses or systemic exposures 10 times the human dose, triptans caused developmental toxicity. Human data, primarily from pregnancy registries, are only available for naratriptan, sumatriptan, and rizatriptan. As of early 2004, about 500 women had been prospectively enrolled, about 90% with first-trimester exposure. Except for a small cluster of five ventricular septal defects, a common heart condition, there was no consistent pattern of defects.

Other than ergot drugs (contraindicated) and amitriptyline (concern for long-term neurotoxicity), all antimigraine agents appear to be compatible with breast-feeding. However, there are few or no data available for gabapentin and topiramate. High doses of ergot alkaloids have been associated with toxicity in nursing infants. The effect of triptans on a nursing infant is unknown, but the small amount of drug found in milk does not appear to represent a risk and it is probable that they are all compatible with breast-feeding.

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