

Expert Opinion

Is Sumatriptan Use Safe During Pregnancy?

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Headache in pregnancy continues to be a vexed question.

CLINICAL HISTORY

This is a 25-year-old (gravida 1, para 0) woman in her 10th week of pregnancy. She offers a 1-year history of migraine without aura. She describes a severe, one-sided throbbing associated with nausea, photosensitivity, and phonosensitivity. If the headache is not treated early, she also vomits. Both before the pregnancy and during the pregnancy thus far, the headaches have been occurring about once per week. Sumatriptan, 50 mg orally, soon after the onset of headache, completely relieves her. She has continued on her own to take sumatriptan during the pregnancy.

Questions.—Is her child at risk for birth defects due to triptan use during the first trimester? What are the risks associated with the use of triptans during the second and third trimester and while breast-feeding? What symptomatic medications do you recommend during pregnancy?

EXPERT COMMENTARY

Any type of drug use in pregnancy can trigger anxiety in the patient and in the physician. Investiga-

tional drug studies are not performed in pregnant women. Thus, any information we have regarding outcomes in the infant are obtained from retrospective data—often of variable reliability. In addition, it often takes thousands of incidents of drug exposure to obtain sufficient data to determine a reliable assessment of a drug's relative risk. This factor was exemplified by the thalidomide exposure during the late 1950s.¹ We must compare the risk to benefit ratio of any abnormality occurring spontaneously.

The frequency with which migraine occurs in pregnancy is not known. Retrospective studies have shown that 60% to 70% of patients reported improvement in migraine during pregnancy.² Newer prospective studies do not necessarily support this older data.³ In the first trimester, particularly, critical organogenesis is occurring and migraine may remain unchanged or worsen.

When considering a recommendation for pharmacologic intervention, one must weigh risks and benefits from treatment. Emphasizing a healthy lifestyle with proper sleep and exercise, and possibly biofeedback training, may be helpful. With those efforts considered, some patients continue to suffer, and drug therapy may be needed to prevent dehydration, anxiety, and depression. All these factors should be considered when medication is needed during pregnancy.

Sumatriptan is a commonly used treatment that is often prescribed during the fertile years. We have very limited data regarding the safety of its use during the first trimester of pregnancy and even less for

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exposure during the second and third trimesters. Glaxo Wellcome established the Sumatriptan Pregnancy Registry in 1996 to prospectively monitor pregnancy outcomes in patients who have had a fetal exposure to this medication. To date, there are 284 patients registered, and no increase relative to an event occurring by chance has been documented.⁴ However, these patient numbers are quite small. Other data comes from an open-label trial with subcutaneous sumatriptan in which 168 patients became pregnant—92 without sumatriptan exposure and 76 with first trimester exposure.⁵ There was no difference in outcome in the infants.

Risk/benefit use of sumatriptan should be used to assess its use as the data we have is still limited. Drugs that are considered safe to use during pregnancy are labeled category B or A. For migraine therapy, the agents include acetaminophen, hydrocodone, some phenothiazines, antihistamines, and butorphanol.

Sumatriptan use during lactation is an easier question. Its concentration in breast milk is quite low and with its bioavailability, there is minimal exposure

to the infant. To try to guarantee the most drug-free breast milk, the patient can pump and discard the next feeding after drug administration, and use supplementation or stored breast milk.

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