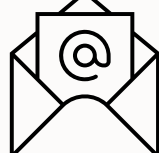


Headache in pregnancy: Just hormones or a red flag waving?

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BACKGROUND

15% of people worldwide are affected by headaches each day. Benign, primary headaches (migraine and tension-type) are most burdensome in women during their reproductive years making headache an exceedingly common reason for presentation to maternity services during pregnancy. Headaches may be hormonally driven. However, they may also herald the onset of serious, life-threatening conditions such as **eclampsia** or **cerebrovascular events** which require prompt evaluation and management.

CASE PRESENTATION



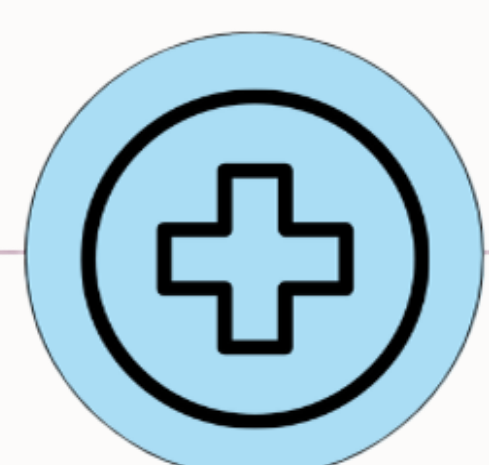
DAY 0

Elective repeat caesarean section under spinal anaesthesia.



DAY 3

Discharged home with simple analgesia. No concerns immediately postnatally and normotensive on discharge.



DAY 7

Presented to the postnatal ward complaining of **moderate occipital headache** radiating to her neck. Normotensive and normal neurological examination. Discharged with simple analgesia.



DAY 10

Represented to the postnatal ward with **worsening headache now associated with nausea** but no vomiting. There were no other associated symptoms. Normotensive and repeat neurological examination was normal.

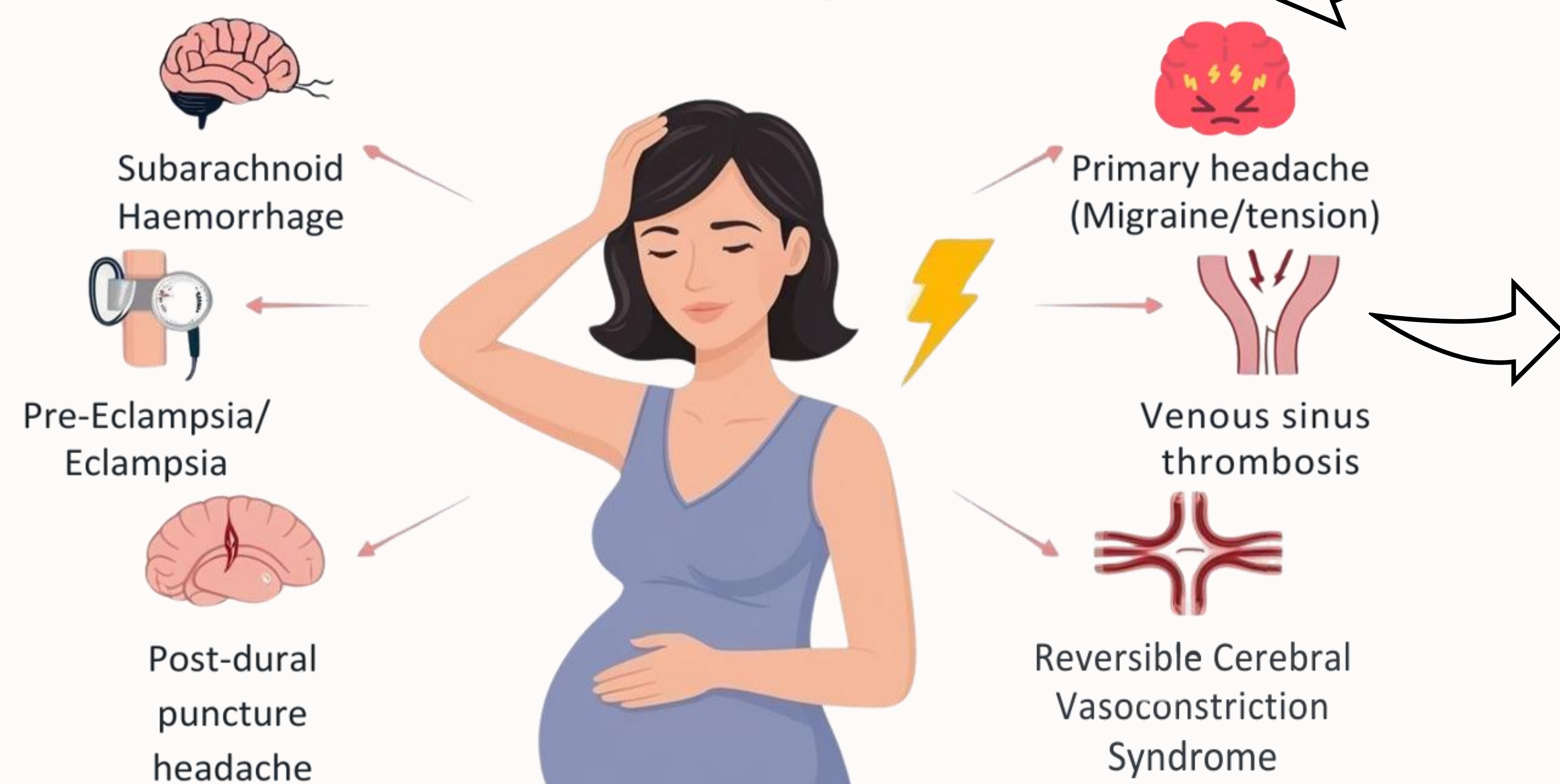
Background History:

35 year old, Gravida 2, Para 2
PMHx: Crohn's Disease – stable on adalimumab which was stopped in the third trimester of pregnancy.
This pregnancy: Uncomplicated antenatal course. Elective repeat caesarean section at 39 weeks.
OBHx: 1 previous elective caesarean section for breech presentation. Uncomplicated pregnancy.

DISCUSSION

This case highlights that even in the **absence of typical red flag features** of a secondary headache, this should be considered in pregnant woman presenting with atypical symptoms. The differential diagnosis of a headache during pregnancy and the puerperium is broad and requires careful consideration. The decision to further evaluate those presenting with textbook symptoms and neurological signs is relatively straightforward. However, deciding who needs further workup when presenting with headache alone is more complex. Pregnancy increases the likelihood of both primary and secondary headaches, and a new headache during this time should be considered a **red flag** and prompt further investigation.

Differential Diagnosis



Day 10: Reviewed by anaesthetics and medical teams with initial impression of a **severe dural puncture headache**. There was a low index of suspicion for the presence of intracranial pathology. Despite the **absence of typical red flag features**, our patient complained of a persistent severe headache and a decision to proceed with imaging was made.

CT brain: Acute bilateral parietal subarachnoid haemorrhage.
Angiography: No evidence of aneurysm. No evidence of RCVS

Lab work: Vasculitis screen - negative

Further management:

- Neurosurgical opinion sought: Recommended conservative management. Short course of nimodipine for neuroprotection.
- Commenced on levetiracetam for persistent clonic movement of her right thumb.
- Resolution of bleed on 3/12 interval imaging.

Final diagnosis: Atraumatic, non-aneurysmal bilateral subarachnoid haemorrhage of unclear aetiology

Suggested triage algorithm for the assessment of headache during pregnancy and the puerperium

