(See page 40)

One

Q1 (a) (b) (c) (d) (g). Answers (c) and (d) are crucial. You must not assume that her new pattern of headache (more frequent) is just a change in her migraine associated with pregnancy. The two may be unrelated, and you must rule out more serious causes of pregnancy-related headache regardless of her history of migraine. Answer e) is also vital as you may need to change her routine and her medication to protect the foetus (see answers to Q3).

Two

Q2 (a) (b) (c) (d) (e). All of these answers should feature in her non-pharmaceutical management. Sudden stopping of all caffeine drinks may precipitate an attack, so if she is drinking an excess of them (say four or more cups of coffee a day) she could cut down on them slowly, but she does not have to avoid them completely.

Three

Q3 (a) (b) and (c). Answers (d) and (e) are wrong. Low dose betablockers such as propranolol have recently been shown not to be linked to a higher risk of congenital anomalies. The same goes for low dose amitriptyline at night. The anti-emetics listed in (f) are all safe to use in pregnancy.

Four

Q4 (a) (b) (c) (d) are all complications of pregnancy that are more frequent in migraine sufferers, and Mary should be aware of the need to recognise any early symptoms of them and to attend all her clinic appointments, where urine and blood pressure tests will pick up any early changes. Glaucoma is not a particular risk in migraine, and orthostatic headache (acute headache on changing posture) is a red flag for an impending stroke not necessarily linked to a migraine attack. It should be treated as an emergency in all pregnancies regardless of a history of migraine.

Mary sailed through her pregnancy: her headaches were tension headaches probably linked with anxiety. Once reassured, and given advice on how to deal with her anxiety, they disappeared. She was one of the lucky ones – her migraines diminished to almost nothing during her pregnancy.