

Table 8.3 ED medications for headache during pregnancy

Drug	FDA Class	Dose	Comments
<i>Anti-emetics</i>			
Ondansetron (Emeset, Emetron, Ondemet, Zofran)	B	4–8 mg IV over 2–5 minutes. May use IM if poor venous access.	Well tolerated. Preferred by obstetricians.
Metoclopramide* (Reglan)	B	10–20 mg IV	More effective than hydromorphone alone [41]. Metoclopramide 20 mg IV shown to be as effective as SQ sumatriptan (Imitrex) [15]. Watch for akathisia.
Promethazine (Phenergan, Promethegan)	C	12.5–25 mg IM	Both anti-emetic and antihistamine components may improve migraine. Watch for akathisia.
Droperidol (Inapsine)	C	2.5–5 mg IM	May be more effective in relieving headache pain than prochlorperazine [17]. As effective as opioid [18]. Black box warning for QT prolongation; not recommended.
Prochlorperazine* (Compazine)	C	10 mg IV	As effective as metoclopramide (Reglan) [16]. Watch for akathisia.
Trimethobenzamide* (Tigan)	C	200 mg IM	Limited human data suggest possible increased risk of congenital anomalies. Use cautiously.
<i>Pain medications</i>			
Magnesium sulfate	B	1–2 g IV	As effective as metoclopramide [27].
Tramadol (Ultram)	C	100 mg IM	Similar efficacy to IM NSAID in non-pregnant patients [23]. Not readily available at all centers.
Hydromorphone (Dilaudid)	C	1–2 mg IM or SQ 0.5–1 mg IV over 2–3 minutes	Avoid prolonged use. Use at term may result in neonatal respiratory depression.
Dexamethasone	C	4–10 mg IV	Minimal efficacy in typical acute migraine; beneficial for migraine lasting >72 hours [34].

*FDA risk category B drug diphenhydramine (Benadryl) may be administered as 25 mg IV in patients experiencing restlessness after receiving anti-emetics.

IM=intramuscular; IV=intravenous; SQ=subcutaneous.