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Common Prenatal Problems

NAUSEA AND VOMITING

- begins @ 6 wks, peaks @ 9 wks; 60% resolve by 12 wks, 91% by 20 wks, 5% entire preg
- women with N&V have fewer spont. abortions and stillbirths vs. women without N&V
- hyperemesis gravidarum = most severe form of NV occurs in < 1%

1st line treatment

Start Diclectin (combo of 10 mg doxylamine + 10 mg pyridoxine)
- recommended dose = 4 tabs daily (2 qhs + 1 qam + 1 qafternoon)
- up to 8 tabs daily, adjust prn, delayed action (takes 8 h to work)

2nd line treatment

Add or switch to a substitute: antihistamines, e.g. dimenhydrinate, diphenhydramine
- for acute or breakthrough NV, use IV and PR formulation

3rd line treatment

If ***dehydrated***:
- **warning signs: wt loss, oliguria**
- hospitalize with IV fluid replacement, multivitamin IV, antiemetic IV

If ***well-hydrated***, add or switch to a substitute (in order of fetal safety):
- phenothiazines, e.g. chlorpromazine; metoclopromide; ondansetron

4th line treatment

Corticosteroids, e.g. methylprednisolone, consider only in refractory cases
- avoid corticosteroids at ≤ 10 wks because of higher risk of oral clefting

Consider other causes or exacerbating factors, test:
- electrolytes, Cr, Bun, liver function, TSH, drug levels, U/S and *H. pylori* testing

Notes

Diet and lifestyle Δs, including:
- eat what appeals, avoid triggers, smaller frequent meals, rest plenty
- stop prenatal multivitamin with Fe (Fe causes gastric irritation/ N&V)

Adjuvant treatment can be added at any time, including:
- ginger supp (in any form, maximum dose = < 1 g per day)
- pyridoxine, acupressure, acupuncture

HEARTBURN AND ACID REFLUX

1st line	Antacids (avoid Mg triscilicate and bicarbonate-containing antacids)
2nd line	- H2 antagonists, e.g. ranitidine - PPIs, e.g. omeprazole, pantoprazole
AVOID	Pepto Bismol because of salicylate absorption
Notes	Lifestyle modifications, including: eat smaller and more frequent meals, avoid eating near bedtime, elevate head of bed

URINARY TRACT INFECTION

-treat asympt. bacteriuria; if not, ↑ risk of cystitis, pyelonephritis & preterm labour

1st line	Penicillins, cephalosporins, fluoroquinolones, nitrofurantoin, phenazopyridine
AVOID	- nitrofurantoin ≥ 38 wks → hemolytic anemia in fetus or newborn - TMP-SMX in first trimester → neural tube defects - TMP-SMX ≥ 32 wks → increased kernicterus in newborn - tetracycline / doxycycline → deposition on bones and teeth
Notes	Prophylactic treatment (if desired): vit C 500 mg daily, cranberry juice

HEADACHE

- **warning signs of severe preeclampsia:** sudden onset in 3rd trimester with vision changes, RUQ pain, facial edema +/- ↑ BP
- treatment: increase sleep & fluid intake, acetaminophen
- **avoid** NSAIDS → teratogenic < 12 wks, ↓ amniotic fluid ≥ 12 wks

LOW BACK PAIN

treatment:
- back exercises
- chiropractic
- physiotherapy

Key References: Arsenault M, and Lane CA. The Management of Nausea and Vomiting in Pregnancy. *SOGC Clinical Practice Guidelines Number 102*. Ottawa: SOGC, 2002; Law R, Maltepe C, Bozzo P, and Einarson A. Treatment of Heartburn and Acid Reflux Associated with Nausea and Vomiting During Pregnancy. *Can Fam Physician* 2010, 56(2): 143-4; Lee M, Bozzo P, Einarson A, and Koren G. Urinary Tract Infections in Pregnancy. *Can Fam Physician* 2008, 54(6): 853-4.