Minor ailments in pregnancy: 
a basic approach

Introduction

Many dilemmas exist when assessing the impact of a drug on a pregnant women and her developing foetus. It is not always easy or ethical to perform randomised controlled studies in pregnant women to demonstrate drug safety.

The US Food and Drug Administration (FDA), classify the risk of drugs during pregnancy as follows:1

A
“Controlled studies show no risk. Adequate, well-controlled studies in pregnant women have failed to demonstrate risk to foetus.”

B
“No evidence of risk in humans. Either animal findings show risk but human findings do not; or, if no adequate human studies have been done and animal findings are negative.”

C
“Risk cannot be ruled out. Human studies are lacking, and animal studies are either positive for foetal risk or lacking as well. However, potential benefits may justify the potential risk.”

D
“Positive evidence for risk. Investigational or post marketing data show risk to the foetus. Nevertheless, potential benefits may outweigh the potential risk.”

X
“Contraindicated in pregnancy. Studies in animals or humans, or investigational or post-marketing reports, have shown foetal risk which outweighs any possible benefit to the patient.”

Most minor ailments in pregnancy do not require drug treatment. However, many drugs can be used safely in pregnancy.

The midwife is usually the first health worker to be consulted by the pregnant patient. Must therefore have a basic understanding of the physiological changes induced by pregnancy and the possible untoward effects of certain drug groups as classified by the FDA.

The aim of this article is to provide a simple approach to manage the common minor ailments the midwife is likely to encounter.

Morning sickness

Nausea with or without vomiting, is one of the most common complaints pregnant patients present with. It occurs any time of the day despite being referred to as morning sickness. Its aetiology is unknown but various theories have been suggested.

Morning sickness is usually mild and transient and resolves spontaneously by the end of the first trimester. However, some cases may be severe and protracted (hyperemesis gravidarum), inducing a variety of debilitating and life-threatening complications. Patients with significant ketonuria, dehydration and those who cannot retain food and fluids need urgent referral to a central facility.

The initial management should be to advise lifestyle changes. These include avoiding fatty meals and aroma that trigger nausea. Iron tablets should preferably be avoided in the first trimester of pregnancy as they may also induce nausea and vomiting.

Studies have shown that Ginger is effective in relieving symptoms. Fischer-Rasmussen et al. conducted a randomized trial of ginger for the treatment of morning sickness. After 4 days, there was a significant reduction in both nausea and vomiting in patients receiving 125mg of ginger six hourly.

Pyridoxine (Vitamin B6) 10mg every eight hours, has also been shown to effectively relieve the symptoms of severe nausea. Emex and Emetrol are reportedly safe to use in pregnancy.

Most anti-emetic drugs have been used in the treatment of morning sickness with some degree of success. These drugs are generally FDA category C drugs and should only be used if other measures fail to relieve symptoms.

Heartburn

Gastro-oesophageal reflux disease is common in pregnancy, affecting 30 – 50% of all pregnant patients. Patients report worsening of symptoms during meals and...
at bed time. The aetiological factors include a decrease in the lower oesophageal sphincter pressure due to hormonal changes induced by the pregnancy, delayed bowel transit time and possibly the physical space occupying effects of the gravid uterus. Heartburn may also represent an exacerbation of a pre-existing gastro-oesophageal reflux disease. However, pregnancy induced heartburn resolves soon after delivery.

Complications of heartburn such as oesophagitis and stricture formation are rare in pregnancy induced heartburn, and therefore gastroscopy is usually not necessary.

The management of heartburn has to be in a stepwise fashion, starting with lifestyle changes and dietary manipulation.

**Colds and influenza**

Stuffiness and blocked nostrils are often noted as normal physiological changes induced by the hormonal milieu in pregnancy. About 30% of pregnant women experience significant rhinitis symptoms. The mucosa of the nasopharynx becomes oedematous and hyperaemic causing hypersecretion of mucus, leading to complaints of chronic colds during pregnancy. Polyposis of the nose and nasal sinuses may also develop, leading to worsening of symptoms. These are normal changes in pregnancy, and therefore the temptation to use nasal decongestant sprays in these patients should be avoided. Rhinitis of pregnancy is refractory to treatment but disappears within 48 hours of delivery. Chronic usage of decongestants during pregnancy will cause mucosal atrophy.

Non-hormonal causes of rhinitis must be excluded. These include allergic rhinitis, purulent sinusitis, rhinitis related to physical and emotional stress.

There is no cure for influenza, treatment is merely aimed at symptom relief. Many medicines used for the treatment of the common cold, contain decongestants, antitussives, expectorants and some analgesics. Noncorticosteroidal anti-inflammatory agents (NSAIDs) such as ibuprofen, naproxen and indomethacin are FDA category B drugs. However, they are classified as category D if used in the 3rd trimester because of the association with oligohydramnios and persistence of the foetal circulation when used during this period. There are also reports of persistent pulmonary hypertension in neonates with a closed ductus arteriosus after maternal naproxen ingestion over the four days preceding delivery.

**Vitamin C**

Vitamin C is widely sold and used as a preventative and a therapeutic agent for the common cold. However a Cochrane review of trials which used Vitamin C for treatment of the common cold did not show any benefit in doses of up-to 4g per day.

**Antihistamine drugs**

The safety of these medicines is not established in pregnancy. They are generally category B or C drugs. These drugs should be used in patients with significant symptoms.

**Decongestants**

There are concerns that some patients may develop hypertension and decreased placental perfusion due to the stimulatory effects on the alpha-adrenergic receptors. However, it might be necessary to use these drugs on patients with severe symptoms. Many clinicians consider pseudoephedrine to be the drug of choice in pregnancy.

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**Table I: Management of morning sickness**

<table>
<thead>
<tr>
<th>Line of Therapy</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st line therapy</td>
<td>Avoid greasy meals and aroma</td>
</tr>
<tr>
<td></td>
<td>Avoid iron tablets in first trimester</td>
</tr>
<tr>
<td>2nd line therapy</td>
<td>Emex/Emetrol 15 – 20mls as required</td>
</tr>
<tr>
<td></td>
<td>Pyridoxine 10 - 25mg daily</td>
</tr>
<tr>
<td></td>
<td>Ginger 125mg 6 hourly for 4 days</td>
</tr>
<tr>
<td>3rd line therapy</td>
<td>Antiemetic drugs (usually category C)</td>
</tr>
<tr>
<td></td>
<td>Prochlorperazine</td>
</tr>
<tr>
<td></td>
<td>Metoclopramide</td>
</tr>
<tr>
<td>4th line therapy</td>
<td>Refer for management of dehydration and to prevent complications of hyperemesis gravidarum</td>
</tr>
</tbody>
</table>

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**Table II: Management of heartburn**

<table>
<thead>
<tr>
<th>Lifestyle changes</th>
<th>Stop smoking, avoid alcoholic beverages, elevate head at end of bed when sleeping, chewing gum may help to neutralize gastric acids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary changes</td>
<td>Have frequent, smaller meals rather than 3 large meals, have supper earlier, avoid foods causing heartburn</td>
</tr>
<tr>
<td>Antacids</td>
<td>Mostly safe to use. Rapid relief of symptoms</td>
</tr>
<tr>
<td>aluminium, calcium and magnesium</td>
<td></td>
</tr>
<tr>
<td>Sucralfate</td>
<td>Use in pregnancy acceptable. Relieves symptoms</td>
</tr>
<tr>
<td>Sodium bicarbonate</td>
<td>Do not use in pregnancy, may cause alkalosis</td>
</tr>
<tr>
<td>Histamine2- receptor blockers</td>
<td></td>
</tr>
<tr>
<td>Cimetidine</td>
<td>Effective. FDA category B drug.</td>
</tr>
<tr>
<td>Ranitidine</td>
<td>Effective. FDA category B drug</td>
</tr>
<tr>
<td>Proton pump inhibitors</td>
<td>Rather refer patients</td>
</tr>
<tr>
<td>Omeprazole</td>
<td>Effective. Not first line. FDA category C drug</td>
</tr>
</tbody>
</table>
Decongestants
There are concerns that some patients may develop hypertension and decreased placental perfusion due to the stimulatory effects on the alpha-adrenergic receptors. However, it might be necessary to use these drugs on patients with severe symptoms. Many clinicians consider pseudoephedrine to be the drug of choice in pregnancy.

Backache and lower abdominal pains
The mechanical effects of the progressively enlarging gravid uterus cause an alteration in the posture of the lumbar spines, leading to an exaggerated lumbar lordosis. This then leads to lower back pain in many pregnant women. The high concentrations of relaxin and progesterone in pregnancy, cause softening and laxity of the pubic joints. Symphyses pubis dysfunction occurs where the joint becomes sufficiently relaxed to allow instability in the pelvic girdle. Tenderness over the symphysis pubis and sacroiliac joints are the commonest clinical signs of symphyses pubis dysfunction. Patients often complain of pain when walking, turning in bed, climbing stairs, rising from a chair or when standing on one leg. The differential diagnosis includes sciatica, oestus pubis, urinary tract infection, anmiotic fluid infection syndrome, round ligament pain and other pathologies.

Management
Support from the midwife and family is essential. Activities that cause discomfort must be avoided. Pain medicine such as paracetamol with/without codeine can be given. The physiotherapist can advise on back care and strategies to avoid activities that put undue strain on the pelvis. Elbow crutches may be provided where weight bearing is painful. Bed-rest is advised but these patients must then be given anti-coagulation therapy and stockings to prevent thrombo-embolic complications.

It is essential to reassure the patient that symphyses pubis dysfunction is not dangerous to mother or foetus if managed properly.

Constipation
Constipation is a common problem in pregnancy. It occurs due to reduced bowel motility, increased water and salt re-absorption from the colon, and due to the obstructive mechanical effects of the uterus. It tends to get worse as the pregnancy progresses. Patients may develop severe discomfort and pain if not managed adequately.

Management
Increased fluid intake
Increasing fluid intake does not have an important effect on colonic function, and it is not recommended to treat constipation unless there is evidence of dehydration. High fibre diet Patients must be advised to increase fibre intake initially. Dietary modification such as increased intake of fresh fruit, vegetables and adding bran or wheat can usually help. These patients must be requested to have follow up visits to determine if there has been any improvement in stool consistency, as constipation due to slow transit time might actually get worse with a high fibre diet. Laxatives are usually not necessary, however if there is no improvement, laxatives that stimulate the bowel are more effective than those that add bulk. Studies have reported a good response to a single dose of 7.5mg senna.

Skin changes
Oedema
Pregnancy causes a generalised increase in soft tissue mass attributed to hormonally mediated increase in capillary permeability and sodium and water retention. The eyelids, face and hands are particularly affected. One of the more common discomforts of pregnancy namely carpal tunnel syndrome, is the result of this change. In the legs, the hormonally mediated pitting oedema is aggravated by the obstructive effects of the gravid uterus. These changes also predispose pregnant patients to varicose vein development.

The patient must be advised to elevate her legs, avoid sleeping on her back and to immobilise the wrist with removable splints especially at night.

Striae Gravidarum
Stretch marks begin as pink to violet thinning in the surface of the abdominal, breast and thigh skin. They usually fade to a lighter colour postpartum, but the skin defects persist. Various creams have been used to treat these skin changes with varying degrees of success. Massage may also be of benefit.

Hyperpigmentation
The majority of pregnant patients will develop increased pigmentation, especially the darker skinned individuals. It occurs most frequently on the face, thighs, linea nigra and the areola of the breasts. The hyperpigmentation is usually progressive and aggravated by sun exposure. It mostly regresses postpartum although not completely.

Patients should be advised to avoid excessive sun exposure.

Conclusion
Many of these minor ailments will get worse if not treated earlier. The midwife has a very important role to play in treating patients, educating patients and managing minor conditions, therefore preventing many hospital admissions. Treatment must be individualized and serious conditions must be excluded and referred without delay. If you are not sure, rather refer.

References: