

"Morning Sickness" – An overview

by Michele Brown, MD, FACOG

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Nausea and vomiting often referred to as 'morning sickness' are common and extremely distressing symptoms of pregnancy. The term "morning sickness" is a misnomer as most women suffer from these symptoms throughout the day.

Women often experience some nausea in the early stages of pregnancy. In most cases the symptoms are mild transient and easily managed by dietary modifications. In some cases however, the symptoms may be severe. Relentless vomiting can last the entire pregnancy and be associated with dehydration and weight loss.

Even in the milder cases nausea and vomiting can affect the pregnant woman's outlook on the pregnancy, lead to significant distress, and interfere with the nutritional requirements.

Some important facts about nausea and vomiting in pregnancy

- **Incidence:** Nausea and vomiting of pregnancy are extremely common and occur in 50 to 80% of pregnant women.
- **Time of occurrence:** In most cases symptoms usually appear by the 5th week and disappear by the 13th week of pregnancy. Severity peaks between 11 and 13 weeks. However, in 20% of women, nausea and vomiting can persist throughout pregnancy.
- The Causes of nausea and vomiting in pregnancy are largely unknown. However, the following associations have been noted.
 1. Conditions in which pregnancy hormone levels are high (twin pregnancy, molar pregnancy) are associated with a higher incidence of nausea and vomiting. On the other hand, women whose pregnancy hormones are low (smokers) have a lower incidence of nausea and vomiting.
 2. Women taking prenatal vitamins are less likely to have severe nausea and vomiting.
 3. Psychological causes and transformation of a mental disorder into physical symptoms (psychosomatic conditions) have little supporting evidence as the cause of nausea and vomiting. However, nausea and vomiting especially in their severe forms can cause severe psychological



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4. Genetic susceptibility: A history of hyperemesis is found in other family members suggesting a genetic link.
5. History of nausea and vomiting in a previous pregnancy suggesting individual susceptibility.
6. History of migraine headaches is linked to nausea and vomiting.
7. Women on their first pregnancy are less likely to develop hyperemesis as compared to subsequent pregnancies.
8. Nausea and vomiting are more commonly found when the interval between pregnancies is short.

Hyperemesis Gravidarum:

An extreme form of this common symptom. In 1 to 3% nausea and vomiting are severe leading to dehydration and electrolyte imbalance and weight loss occasionally requiring hospitalization.

In addition to the severe psychological impact of hyperemesis, it can also lead to serious pregnancy complications or death;

- Rupture of the esophagus and bleeding from ruptured blood vessels.
- Wernicke's encephalopathy—a rare but serious brain disorder associated with Vitamin B1 deficiency and leading to memory loss, visual disturbances, and gait disturbances.
- Low birth weight as a result of malnutrition.
- Pregnancy termination due to severe psychological distress and depression.

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Treatment of nausea and vomiting in pregnancy:

In most cases the purpose of the treatment is to improve the pregnant woman's quality of life. In cases of hyperemesis treatment is essential and can be lifesaving.

No single specific treatment is effective in all women. A carefully tailored multidisciplinary approach which includes dietary modifications, herbal remedies and medication should be adjusted to the woman's needs. Emotional support is extremely valuable.

Dietary Suggestions

- Avoid foods and odors that might trigger the symptoms.
- Eat bland high protein and carbohydrate foods and snacks—avoid fatty, spicy foods, short frequent meals help. Solid starches such as potatoes, rice, and pasta are recommended.
- Stop all iron tablets.
- Avoid dehydration (1.0 to 1.5 liter) by drinking sports drinks and bouillon which contain salt, glucose, and potassium. Ginger ale is another traditional remedy. Advance to broth soups with noodles or rice. Avoid cream based soups because of fat content.

Herbal and natural remedies

- Vitamin B6 (pyridoxine 10-25 mg taken 3 or 4 times a day) is used due to its anti-emetic properties. An antihistamine (doxylamine sold as over the counter as Unisom sleep tabs 1/2 tab) can be added to the pyridoxine as first line therapy (10 mg of each).
- Ginger tablets (250 mg given 3 or 4 times a day or powdered ginger extract 1 gram/day).
- Acupuncture, acupressure (wristbands), and hypnosis.

Drug Therapy

In most cases the condition can be managed on an outpatient basis with close follow up by the obstetrician to ensure proper hydration and nutrition.

- Drugs that are administered on an outpatient basis fall into the following categories 1. Antiemetic drugs. e.g. Zofran, Tigan, Reglan, 2. Phenothiazines e.g. Promethazine, 3. Anti-histamines and 4. Steroids.
- IV fluid therapy, intravenous nutrition and hospitalization may be required for those women who

are severely dehydrated. In addition to proper hydration, intravenous medications are used (Reglan, Phenergan, Dramamine, and Zofran).

Tigan suppositories can also be of value in women who cannot tolerate oral medications.

Steroid therapy has been reported to be successful in some resistant cases but should be avoided if possible due to the associated risk of fetal malformation (cleft palate) when given within the first 10 weeks of pregnancy.

- Vitamin B1 therapy: All women who have been vomiting for 3 weeks and require IV hydration should be given supplemental vitamin B1 to prevent Wernicke's encephalopathy.

In summary: Nausea and vomiting of pregnancy is extremely common and a normal part of a healthy pregnancy in most cases. In severe cases, hospitalization may be necessary along with lost time from work, and multiple visits to your obstetrician. There are multiple theories and mechanisms that can cause this problem.

