Common Problems in Pregnancy

Minor symptoms are very common in pregnancy. The symptoms should be properly assessed in case they represent more serious health problems in the pregnancy. Otherwise, it is essential to provide reassurance and advice. Medication is not usually required and is best avoided if possible. [1]

Nausea and vomiting in early pregnancy [2, 3]

- Nausea and vomiting are common in early pregnancy, affecting 90% of women and causing a clinically significant problem in 35% of those affected.
- Hyperemesis gravidarum occurs in less than 1% of pregnancies.
- Most cases of nausea and vomiting in pregnancy are self-limiting and settle without complication as the pregnancy progresses.
- Where intervention is required, Cochrane reviews have not found benefit of any one treatment over another. [4] The National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary (CKS) recommends where benefit of treatment outweighs risk and anti-emetics are needed, promethazine or cyclizine should be used first-line.

See the separate Nausea and Vomiting in Pregnancy - including Hyperemesis Gravidarum article for more information.

Dyspepsia [1, 5]

- Dyspepsia is common in pregnancy and becomes more prevalent as pregnancy progresses. 40-80% of women have dyspepsia at some stage of their pregnancy.
- Symptoms of heartburn may be helped by lifestyle changes such as:
  - Sitting up rather than lying down just after eating.
  - Sleeping in a propped-up position by raising the foot of the bed.
  - Changing the way the woman eats - for example, small frequent meals, not eating within three hours of going to bed.
  - Reduce gastric irritants such as fatty or spicy foods, fruit juice, chocolate and caffeine.

- Antacid preparations such as Gaviscon® reduce reflux symptoms. Antacid products containing combinations of aluminium and magnesium or calcium may be used as required, but those containing sodium bicarbonate or magnesium trisilicate should be avoided in pregnancy.
- Acid suppressant medication such as ranitidine or omeprazole may be considered if symptoms are severe and not controlled with antacids. There is no evidence of harm to the fetus but manufacturers usually recommend avoidance in pregnancy.

Constipation [6]

- Constipation is very common in pregnancy, affecting up to 40% of women. [7]
- It can be improved by a high fluid intake, eating high-fibre foods and getting plenty of exercise.
- When this doesn't work, laxatives such as senna which stimulate the bowel into action are most effective, although they may cause more abdominal pain and diarrhoea than bulk-forming laxatives.
Respiratory distress

- Many women feel breathless as the growing uterus pushes the diaphragm upwards into the chest cavity as the pregnancy advances. Other mechanisms such as hormonal influences also contribute as some women may feel breathless earlier in pregnancy.
- The woman may be significantly breathless and other possible causes of respiratory distress (e.g., asthma, pulmonary embolism, anaemia and valvular disease) may need to be ruled out.

Fatigue and insomnia

- Tiredness, or fatigue, is very common in early pregnancy and reaches a peak at the end of the first trimester.
- Rest, trying to do a little less and reassurance that all is well can help a great deal.
- Fatigue also occurs in late pregnancy, when it is important to make sure the patient does not have anaemia.
- Insomnia is also very common and due to a combination of anxiety, hormonal changes and general discomfort.
- Mild physical exercise before sleep may help - sleeping tablets should be avoided.

Pruritus

- Itch has been found to affect as many as 23% of pregnant women.
- Generalised itching is common in the last twelve weeks of pregnancy and disappears after delivery.
- Localised itching is usually due to infections, such as scabies and thrush.
- Dermatological conditions specific to pregnancy which present with a rash include polymorphic eruption of pregnancy, atopic eruption of pregnancy and pemphigoid gestationis.
- Exclude obstetric cholestasis by checking LFTs (raised AST/ALT; alkaline phosphatase is increased in normal pregnancy and so an unreliable marker of cholestasis in pregnancy). There is no rash and it must be considered, as it may cause fetal complications. If a woman presents with an unexplained itch without a rash, LFTs should be monitored every 1-2 weeks until the itch resolves.
- Emollients are the mainstay of treatment in pregnancy.

Haemorrhoids

- Treatment for haemorrhoids includes diet modification, topical soothing preparations (such as Anusol HC®) and surgery.
- Surgery is rarely considered an appropriate intervention for pregnant women, as haemorrhoids may resolve after delivery.

Varicose veins

- Varicose veins are more likely to become apparent when a woman is pregnant. This is due both to pressure on the vena cava (and therefore the pelvic veins) from the weight of the pregnancy, and to increased venous elasticity as a consequence of the hormonal milieu of pregnancy. Whilst varicose veins most commonly occur in the legs they also frequently develop in the vulva where they can cause throbbing and aching. They are more common in those with a genetic susceptibility.
- When varicose veins are present, feet and ankles can also become swollen, in which case deep vein thrombosis and pre-eclampsia should be excluded.
- Treatment is by elevation of legs when sitting, use of compression stockings, and encouragement to walk and to avoid standing still.
Vaginal discharge

- Women usually produce more vaginal discharge during pregnancy.
- If the discharge has a strong or unpleasant odour, is associated with itch or soreness or associated with dysuria, then infection should be excluded.
- *Trichomonas vaginalis* is associated with adverse pregnancy outcomes but the effect of metronidazole for its treatment in pregnancy is unclear.\[10\]
- A topical imidazole is an effective treatment for thrush but a seven-day course may be required in pregnancy. The effectiveness and safety of oral treatments for thrush in pregnancy are uncertain and these should be avoided.

Backache

- Many women develop backache during pregnancy and it often first develops during the fifth to seventh months of pregnancy.
- Encourage light exercise and simple analgesia, and consider physiotherapy referral.
- Evidence shows exercise to be of benefit.\[11\]

Pelvic pain

- Mild crampy pains are normal in very early pregnancy. As the uterus grows, pulling and stretching of pelvic structures causes ligament pain, which usually resolves by 22 weeks. Pain is usually lateral and shooting in nature.
- See separate Pelvic Pain article, which may present as a result of a variety of obstetric and non-obstetric causes.
- Obstetric causes of acute pelvic pain include miscarriage, ectopic pregnancy, red degeneration of a fibroid, torsion of ovarian mass, rupture of ovarian cyst, preterm labour, placental abruption and uterine rupture.

Pelvic girdle pain/symphysis pubis dysfunction\[12, 13\]

- Pelvic girdle pain (PGP) is the newer term for the condition which used to be known as symphysis pubis dysfunction (SPD). It describes pregnancy-associated pain, instability and dysfunction of the symphysis pubis joint and/or sacroiliac joint.
- 14-22% of pregnant women may have PGP.
- There is a collection of symptoms of discomfort and pain in the suprapubic or low back area, which may radiate to the upper thighs and perineum.
- Discomfort can vary from mild to severe pain. There may be difficulty walking or weight bearing, limited and/or painful hip abduction, discomfort lying in certain positions, and a limited endurance of time sitting.
- There is evidence for efficacy of osteo manipulative therapy and for combined treatments of manual therapy plus exercise plus education.\[11\] There is also some evidence that acupuncture may be effective. It may be necessary to provide women with belts or crutches and there may be a need for analgesia in pregnancy and advanced planning for delivery. Management is usually collaborative and involves physiotherapists, midwives, obstetricians and the GP.
- Pain resolves within six months of delivery in the majority of affected women.

Peripheral paraesthesia

- Fluid retention leads to compression of peripheral nerves.
- This often leads to carpal tunnel syndrome, which is very common in pregnancy. Prevalence quoted in the literature varies from 2% to up to 70%.\[14\]
- Often, no specific treatment is required. Interventions include wrist splints, steroid injections and analgesia but there is a lack of research evaluating effective interventions.
- Other nerves can be affected - eg, the lateral cutaneous nerve of the thigh.
Leg cramps

- Leg cramps are common in pregnancy.
- They occur in late pregnancy and are usually worse at night.
- Massaging the affected leg and elevation of the foot of the bed may help.
- Of the various supplements claimed to help leg cramps in pregnancy, the best evidence is for magnesium lactate; however, evidence remains conflicting. [15]

Further reading & references

- Antenatal care for uncomplicated pregnancies; NICE Clinical Guideline (March 2008, updated 2017)
- Nausea/vomiting in pregnancy; NICE CKS, June 2013 (UK access only)
- Dyspepsia - pregnancy-associated; NICE CKS, December 2012 (UK access only)
- Constipation; NICE CKS, October 2015 (UK access only)
- Itch in pregnancy; NICE CKS, July 2015 (UK access only)
- Vaughan Jones S, Ambros-Rudolph C, Nelson-Piercy C; Skin disease in pregnancy. BMJ. 2014 Jun 3;348:g3489. doi: 10.1136/bmj.g3489.
- Management of trichomonas vaginalis; British Association of Sexual Health and HIV (Feb 2014)
- Pregnancy-related Pelvic Girdle Pain: Guidelines for Health Professionals; Pelvic Obstetric and Gynaecological Physiotherapy (POGP). 2015

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