The authors and reviewers have made every attempt to ensure the information in the Family Medicine Clinical Cards is correct – it is possible that errors may exist. Accordingly, the source references or other authorities should be consulted to aid in determining the assessment and management plan of patients. The Cards are not meant to replace customized patient assessment nor clinical judgment. They are meant to highlight key considerations in particular clinical scenarios, largely informed by relevant guidelines in effect at the time of publication. The authors cannot assume any liability for patient outcomes when these cards are used.

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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***:	If ***well-hydrated***, add or switch to a substitute (in order of fetal safety):
- **warning signs: wt loss, oliguria** - hospitalize with IV fluid replacement, multivitamin IV, antiemetic IV	- 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.