



Obstetrics and Gynecology

Minor complication of pregnancy



University Of Fallujah
College Of Medicine

Lecture : 1

Stage : 4th Year

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Department: obstetrics and Gynecology

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Learning Objectives

- **Appreciate the causes and management of minor complications of pregnancy.**
- **Be able to provide a differential diagnosis and a management plan for abdominal pain in pregnancy.**

Musculoskeletal problems

1. Backache: is extremely common in pregnancy and is caused by:

- ❑ hormone induced laxity of spinal ligaments
- ❑ a shifting in the centre of gravity as the uterus grow
- ❑ additional weight gain, which cause an exaggerated lumbar lordosis.

Pregnancy can exacerbate the symptoms of a prolapsed intervertebral disc, occasionally leading to complete immobility. Advice should include maintenance of correct posture, avoiding lifting heavy objects (including children), avoiding high heels, regular physiotherapy and simple analgesia (paracetamol or paracetamol–codeine combinations). non-steroidal anti-inflammatory drugs (such as ibuprofen), are not recommended due to the risk of premature closure of ductus arteriosus and oligohydramnios.

PREGNANT WOMAN

①



②



③

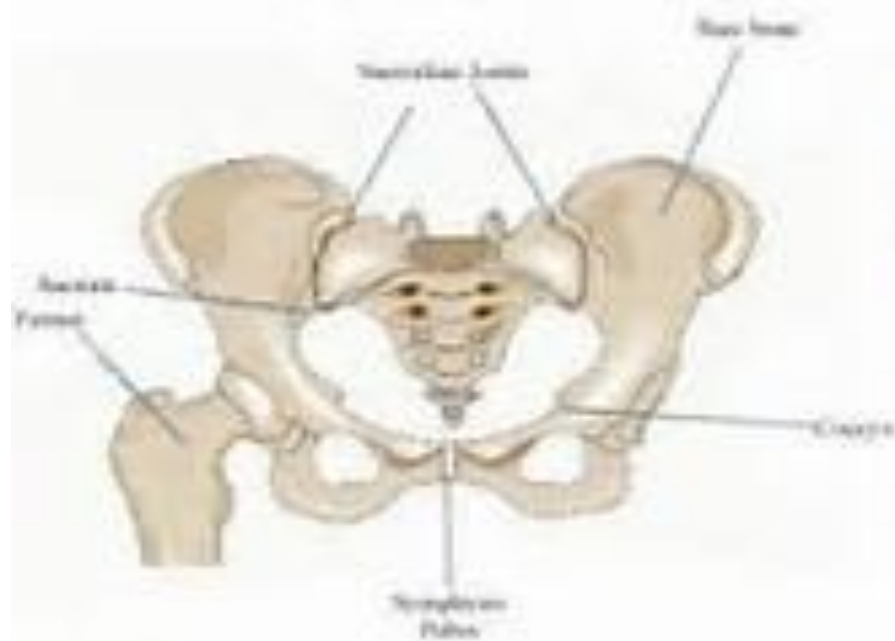


2. Symphysis pubis dysfunction

This is a very painful condition most common in the third trimester, the symphysis pubis joint becomes 'loose', causing the two halves of the pelvis to rub on one another when walking or moving. The condition improves after delivery and the management revolves around simple analgesia.

Under a physiotherapist's direction, a low stability belt may be worn.

Normal Pelvis



Symphysis Pubis Disfunction



3. Carpal tunnel syndrome

- It's a compression neuropathies occur in pregnancy due to increased soft-tissue swelling.
- The median nerve is compress where it passes through the fibrous canal at the wrist before entering the hand.
- The symptoms include numbness, tingling and weakness of the thumb and forefinger, and often quite severe pain at night.
- Simple analgesia and splinting of the affected hand usually help. Surgical decompression is very rarely performed in pregnancy.

Carpal Tunnel Syndrome



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Gastrointestinal symptoms

1. Constipation

- Constipation is common in pregnancy and usually results from a combination of hormonal and mechanical factors that slow gut motility.
- Concomitant administered iron tablets may exacerbate the condition.
- Managements include explanations, reassurance and advice regarding the adoption of a high-fibre diet. Medications are best avoided but if necessary, mild (non-stimulant) laxatives, such as lactulose, may be suggested

2. Nausea and vomiting in pregnancy:

- are extremely common; 70–80 per cent of women experience these symptoms early in their pregnancy.
- the symptoms are often most pronounced in the first trimester, but not confined to it.
- despite common usage of the term ‘morning sickness’, the symptoms can occur at any time.
- nausea and vomiting in pregnancy tends to be mild and self-limited and is not associated with adverse pregnancy outcome.

3. Hyperemesis gravidarum:

- it is a severe, intractable form of nausea and vomiting that affects 0.3–2.0 per cent of pregnancies.
- It causes imbalances of fluid and electrolytes, disturbs nutritional intake and metabolism.
- The aetiology is unknown and various mechanisms have been proposed including an association with high levels of serum human chorionic gonadotrophin (hCG), oestrogen and thyroxine.

Complication of hyperemesis gravidarum:

- Malnutrition and vitamin deficiencies, including Wernicke's encephalopathy (B 1 deficiency)
- Repeated vomiting predisposes to oesophageal trauma and Mallory– Weiss tears.
- increased risk of preterm birth and low birthweight babies.

Treatment includes:

- Dietary and lifestyle changes, as well as alternative therapies such as ginger and acupressure.
- Fluid replacement
- Thiamine supplementation.
- Antiemetics such as phenothiazines are safe and are commonly prescribed.
- Other proposed treatments including the administration of corticosteroids have not yet been adequately proven and remain empirical.
- The NICE has recommended doxylamine/pyridoxine for pregnant women with symptoms that have not responded to standard conservative management.

4. Gastroesophageal reflux

- The weight effect of the pregnant uterus and hormonally induced relaxation of the oesophageal sphincter, explain the extremely high incidence of gastroesophageal reflux in the pregnant population.
- For the majority of patients, lifestyle modifications such as smoking cessation, frequent light meals and lying with the head propped up at night are helpful.
- When these prove insufficient to control symptoms, medications can be added in a stepwise fashion starting with simple antacids. Histamine-2 receptor antagonists and proton pump inhibitors can be used if more simple measures fail although their safety record in pregnancy is less certain.
- Severe symptoms unresponsive to treatments indicated for gastroenterology referral just in case a stomach ulcer.

5. Haemorrhoids

- haemorrhoids more common during pregnancy because of the effects of circulating progesterone on the vasculature, pressure on the superior rectal veins by the gravid uterus and increased circulating volume.
- A conservative approach is usually advocated including local anaesthetic/antiirritant creams and a high-fibre diet.

Varicose veins

- Varicose veins may appear for the first time in pregnancy or pre-existing veins may become worse.
- They are thought to be due to the relaxant effect of progesterone on vascular smooth muscle and the dependent venous stasis caused by the weight of the pregnant uterus on the inferior vena cava.
- Varicose veins of the legs may be symptomatically improved with support stockings, avoidance of standing for prolonged periods and simple analgesia.
- Vulval and vaginal varicosities are uncommon but symptomatically troublesome; trauma at the time of delivery (episiotomy, tear, instrumental delivery) may cause severe bleeding.



Oedema

- This is common, occurring to some degree in approximately 80 per cent of all pregnancies.
- There is generalized soft-tissue swelling and increased capillary permeability, which allows intravascular fluid to leak into the extravascular compartment.
- The fingers, toes and ankles are usually worst affected and the symptoms are aggravated by hot weather.
- Oedema is best dealt with by frequent periods of rest with leg elevation; occasionally, support stockings are indicated.
- It is important to remember that generalized (rather than lower limb) oedema may be a feature of preeclampsia, so remember to check the woman's blood pressure and urine for protein.
- More rarely, severe oedema may suggest underlying cardiac impairment or nephrotic syndrome.





Other common 'minor' disorders:

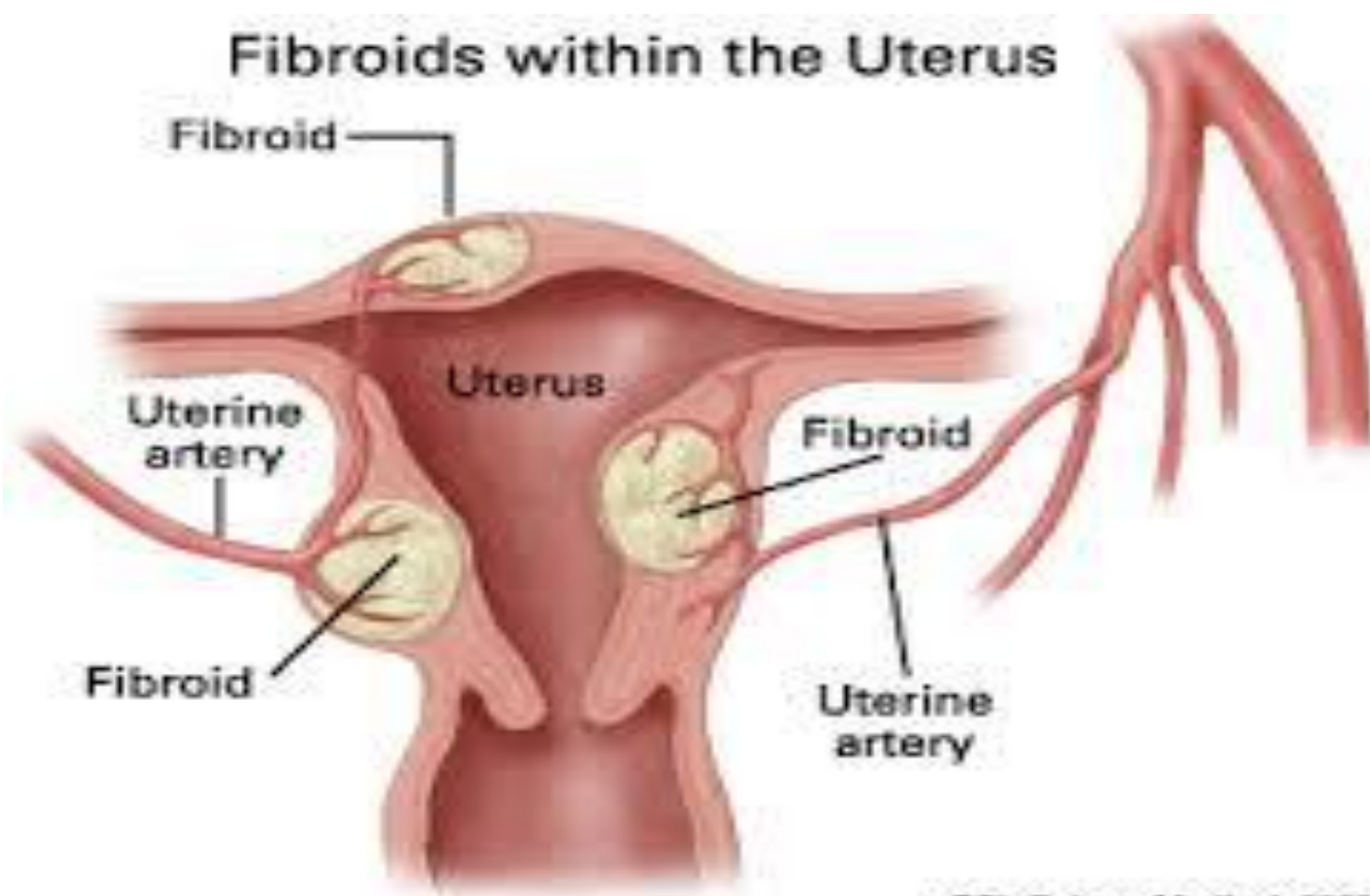
- Itching
- Urinary incontinence
- Nose bleeds
- Thrush (vaginal candidiasis)
- Headache
- Fainting
- Breast soreness
- Tiredness
- Altered taste sensation
- Insomnia
- Leg cramps
- Striae gravidarum and chloasma.

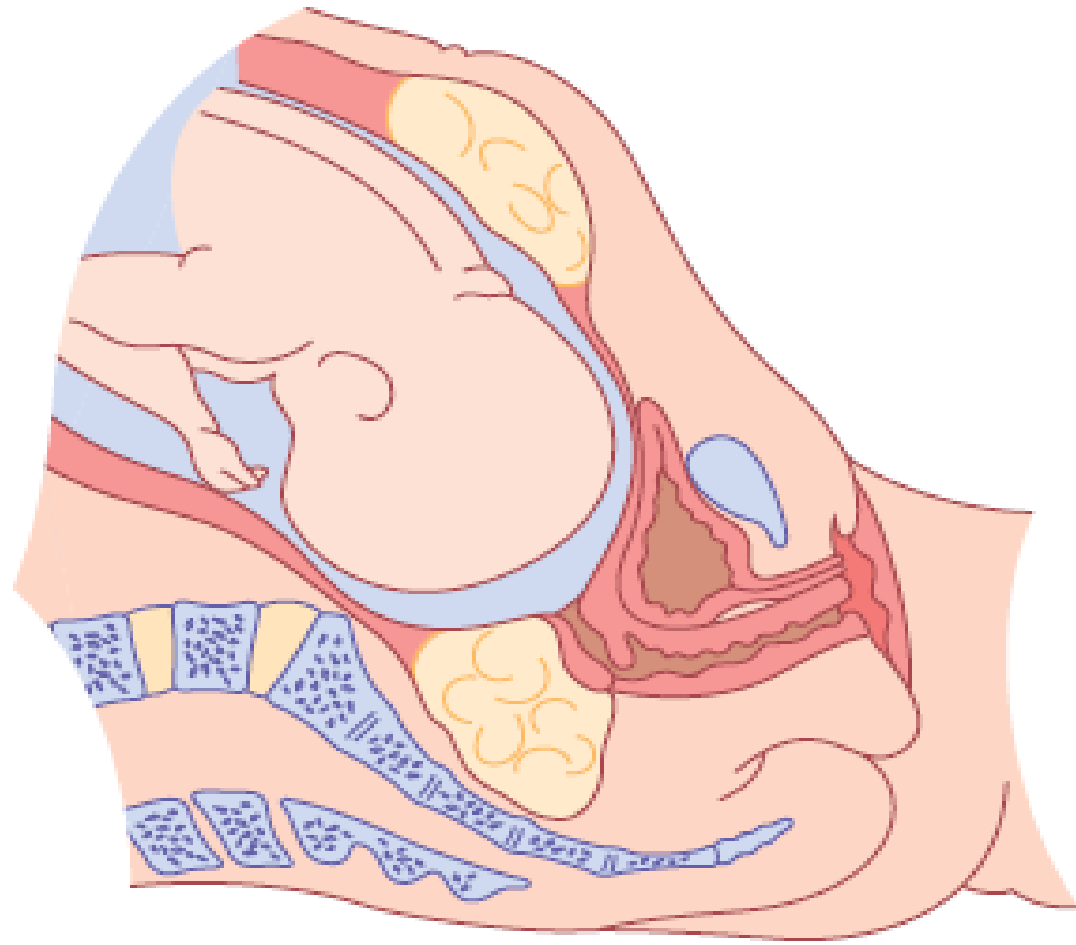
Problems due to abnormalities of the pelvic organs

1. Fibroids (leiomyomata)

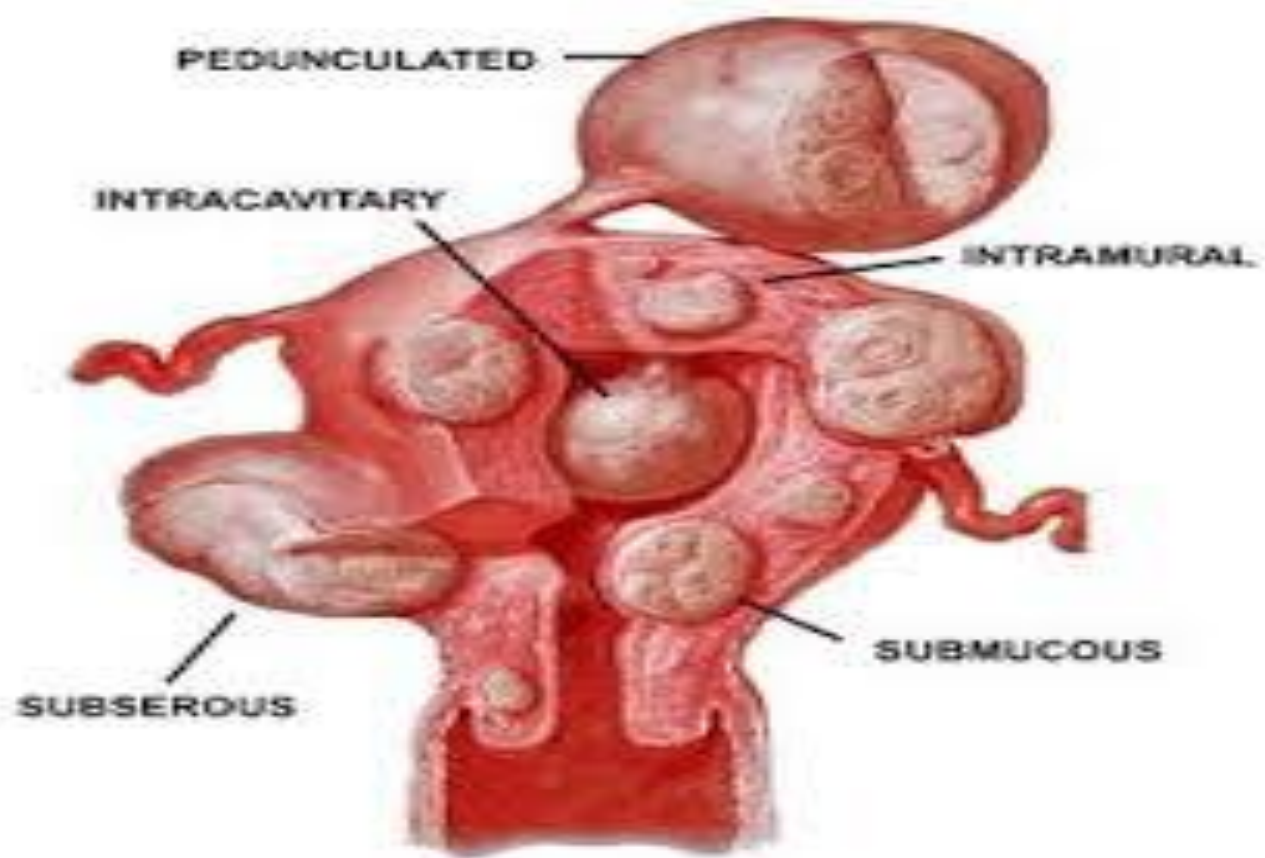
- Fibroids are compact masses of smooth muscle that lie in the cavity of the uterus (submucous), within the uterine muscle (intramural) or on the outside surface of the uterus (subserous).
- Complication of fibroid in pregnancy include:
 - ❑ Fibroid may enlarge in pregnancy, a large fibroid at the cervix or in the lower uterine segment may prevent descent of the presenting part and obstruct vaginal delivery.

Fibroids within the Uterus





- ❑ Red degeneration is one of the most common complications of fibroids in pregnancy. As it grows, the fibroid may become ischaemic; this manifests clinically as acute pain, tenderness over the fibroid and frequent vomiting. If these symptoms are severe, uterine contractions may be precipitated, causing miscarriage or preterm labour. Red fibroid degeneration requires treatment in hospital, with potent analgesics (usually opiates and intravenous fluids). The symptoms usually settle within a few days.
- ❑ A subserous pedunculated fibroid may undergo torsion resulting in acute abdominal pain and tenderness



2. Retroversion of the uterus

- 15% of women have a retroverted uterus.
- In pregnancy, the uterus grows and a retroverted uterus will normally 'flip' out of the pelvis and begin to fill the abdominal cavity, as an anteverted uterus would.
- In a small proportion of cases, the uterus remains in retroversion and eventually fills up the entire pelvic cavity; as it does so, the base of the bladder and the urethra are stretched. Retention of urine may occur, classically at 12–14 weeks, and this is not only very painful but may also cause long-term bladder damage. If the bladder becomes over-distended. In this situation, catheterization is essential until the position of the uterus has changed.



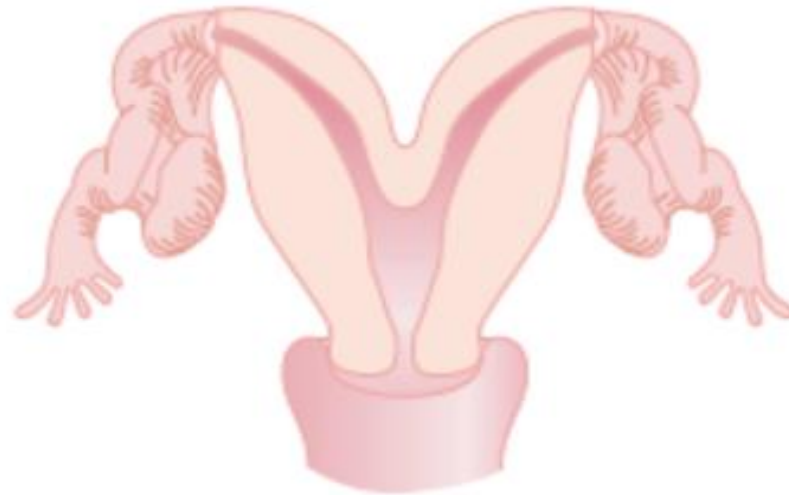
3. Congenital uterine anomalies

The shape of the uterus is embryologically determined by the fusion of the Mullerian ducts. Abnormalities of fusion may give rise to anything from a subseptate uterus through to a bicornuate uterus and even (very rarely) to a double uterus with two cervixes. The problems associated with bicornuate uterus are:

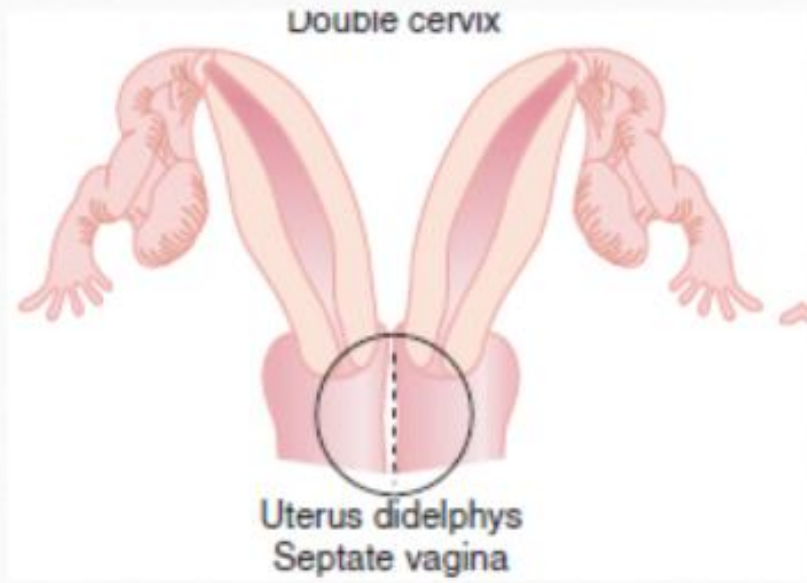
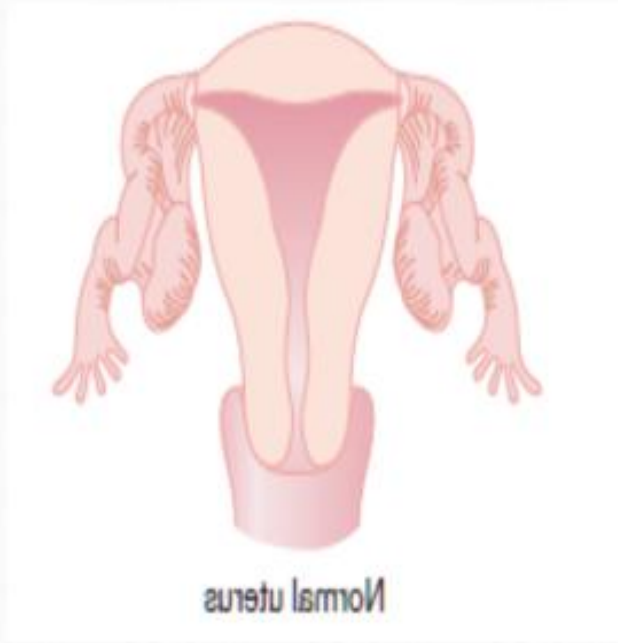
- miscarriage;
- preterm labour;
- abnormalities of lie and presentation;
- higher Caesarean section rate.



Normal uterus

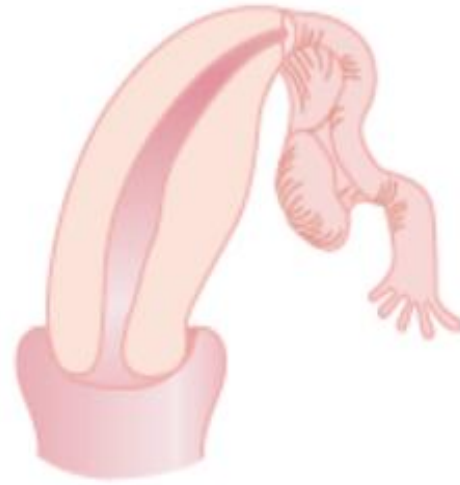


Bicornuate uterus





Normal uterus



Unicornuate uterus

4. Ovarian cysts in pregnancy

- Ovarian cysts are common in pregnant women; fortunately, the incidence of malignancy is uncommon in women of childbearing age.
- The most common types of pathological ovarian cyst are serous cysts and benign teratomas.
- Physiological cysts of the corpus luteum may grow to several centimetres but rarely require treatment, therefore asymptomatic cysts may only require followed up by clinical and ultrasound examination.
- Any ovarian surgery should be avoided as possible in the first trimester to avoid disruption corpus luteum of pregnancy.

- Surgery is usually postponed until the late second or early third trimester, when there is the potential that if the baby were delivered, it would be able to survive.
- Indication of surgical intervention for ovarian cyst in pregnancy include:
 - ❖ The large (6 cm and more) ovarian cysts in pregnancy, which may undergo torsion, haemorrhage or rupture, causing acute abdominal pain. The resulting pain and inflammation may lead to a miscarriage or preterm labour.
 - ❖ Symptomatic cysts, most commonly due to torsion, will require an emergency laparotomy and ovarian cystectomy or even oophorectomy if the cyst is torted.

Urinary tract infection

- Urinary tract infections are common in pregnancy, 80% of women have asymptomatic bacteriuria; if this is untreated, it may progress to UTI or even pyelonephritis, with the associations of low birth weight and preterm delivery.
- The predisposing factors are:
 - history of recurrent cystitis;
 - renal tract abnormalities: duplex system, ureteric damage and stones;
 - diabetes;
 - bladder emptying problems, for example multiple sclerosis.

- The symptoms of UTI: may be different in pregnancy; it occasionally presents as low back pain and general malaise with flu-like symptoms. The classic presentation of frequency, dysuria and hematuria is not often seen. On examination, tachycardia, pyrexia, dehydration and loin tenderness may be present.
- Investigations: should include a full blood count and midstream specimen of urine (MSU) sent for urgent microscopy, culture and sensitivities.
- Treatments: The woman should drink plenty of clear fluids and take a simple analgesic, such as paracetamol. The first-line antibiotic for UTI is amoxicillin or oral cephalosporins.

Pyelonephritis: is characterized by dehydration, a very high temperature (38.5C), systemic disturbance and occasionally shock. This requires urgent and aggressive treatment including intravenous fluids, opiate analgesia and intravenous antibiotics (such as cephalosporins or gentamicin). In addition, renal function should be determined, with at least baseline urea and electrolytes.

Causes of abdominal pain in pregnancy

Obstetric conditions

1. Early pregnancy (<24 weeks)

- Ligament stretching
- Miscarriage
- Ectopic pregnancy
- Acute urinary retention due to retroverted gravid uterus
- Ovarian hyperstimulation

2. Later pregnancy (>24 weeks)

- Labour
- Placental abruption
- Severe pre-eclampsia and/or haemolysis
- elevated liver enzymes and low platelets (HELLP) syndrome
- Uterine rupture
- Chorioamnionitis

Pregnancy-unrelated conditions

1. Uterine/ovarian causes

- Torsion or degeneration of fibroid
- Ovarian cyst accident

2. Urinary tract disorders

- Urinary tract infection (acute cystitis and acute pyelonephritis)
- Renal colic

3. Gastrointestinal disorders

- Medical gastric/duodenal ulcer
- Acute appendicitis, pancreatitis, gastroenteritis, cholecystitis
- Intestinal obstruction or perforation

4. Medical causes

- Sickle cell disease (abdominal crisis) , Diabetic ketoacidosis ,Acute intermittent porphyria , Pneumonia (especially lower lobe) .Pulmonary embolus and Malaria