

THE BEST JOB IN THE WORLD

THE PRACTISING MIDWIFE

Volume 11 no 7
July/August 2008



**NO FORMULA MILK
ADVERTISEMENTS**

BRITAIN'S BEST-SELLING MONTHLY JOURNAL FOR MIDWIVES

Antenatal care

Hyperemesis gravidarum

Caring for the disabled mother

The birth plan

www.thepractisingmidwife.com

Get in touch

Editor

Jennifer Hall

MSc RN RM ADM PGDip (HE)

Senior Lecturer in Midwifery University of the West of England jenny.hall@uwe.ac.uk

Managing Editor

Laura Yeates

020 8464 0304

prac.mid@ntlworld.com

Advertising Manager

Margaret Floate

01483 824094

margfloate@btinternet.com

Publisher

Melanie Burton

m.burton@elsevier.com

All correspondence, articles for publication, marketing, rights and reprint orders should be addressed to: The Editor, TPM Editorial Office, 54 Siward Road, Bromley BR2 9JZ Tel: 020 8464 0304; prac.mid@ntlworld.com

All subscription enquiries or back issue orders should be addressed to: TPM Subscriptions Department, Proact Marketing, 12 Mary Seacole Road, The Millfields, Plymouth PL1 3JY. Tel: 01752 312140; fax: 01752 313162; email: postmaster@proactmarketing.co.uk

Personal subscription rates (UK direct debit rates in brackets):

UK £55 (£45); First year of qualification £45 (£35); Student £25 (£20);

Europe/Eire £64; rest of world £82 (surface) or £105 (airmail)

Institutional/library rates: UK £128 (£100); Europe/Eire (airmail) £154; rest of world (air mail) £186. Payment can be made by cheque payable to 'The Practising Midwife' or by credit card: Mastercard or Visa.

Copyright: © Elsevier Ltd, 2008. All rights reserved. No part of 'The Practising Midwife' may be reproduced in any material form (including photocopying or storing in any medium by electronic means and whether or not transiently or incidentally to some other use of this publication) without the written permission of the copyright holder except in accordance with the provisions of the Copyright, Designs and Patents Act 1988, or under the terms of a licence issued by the Copyright Licensing Agency Ltd, 90 Tottenham Court Road, London, England W1P 0LP. Applications for the copyright holder's written permission to reproduce any part of this publication should be addressed to the publishers.

Printed in Great Britain by Williams Press, Maidenhead ISSN 1461-3123

Disclaimer: The sentiments expressed by the contributors and advertisers in *The Practising Midwife* do not necessarily reflect the views of either the Editor or the Editorial Advisory Board.

Editorial Advisory Board

Anne Adikibi PhD, MEd, BA, RGN, SCM, MTD *Midwife Lecturer, University of Salford*

Helen Baston PhD, RN, BA (Hons), RM, ADM, MmedSci, PGDipEd *Midwife Lecturer/Researcher, University of York*

Susan Crowther RM, RGN, BSc (Hons), MSc *Independent Midwife and Midwifery Consultant, New Zealand*

Deirdre Daly MSc, PGDipEd, BSc (Hons), RM, DipMid, RGN *Lecturer in Midwifery, Trinity College, Dublin*

Declan Devane RGN, RM, RNT, DipHE (Midwifery), BSc(Hons), MSc (Midwifery Education), PGDip (Stats) *Senior Lecturer, School of Nursing and Midwifery, National University of Ireland*

Jenny Fraser MSc, RN, RM, DPSM *Lead Midwife for Risk Management and Clinical Governance, Norfolk and Norwich University Hospital NHS Trust*

Joy James RGN, RM, ADM, Cert Counselling, Dip Counselling, PGCEM, RN, BA, MA *Senior Lecturer, Midwifery, University of Glamorgan*

Mary Nolan PhD, MA, BA, RGN *Professor of Perinatal Education, University of Worcester, and Senior Tutor, National Childbirth Trust*

Becky Reed RM, SRN, BA (Hons) *Group Practice Midwife, Albany Midwifery Practice, London*

Anne Marie Rennie MSc, RM, RGN, ADM, BSc (Hons) *Midwifery, PG Cert HELT Lecturer in Midwifery, The Robert Gordon University*

Mandy Renton RGN, RM, MSc *General Manager Woman and Child Service Unit, Peterborough and Stamford Hospitals NHS Foundation Trust*

Suzanne Truttero MBA, LLB, ADM, RM, RN *Local Supervising Authority Midwifery Officer for London*

Verena Wallace MSc (HPPF), PGDip, MSc, ADM, RM, RN *Local Supervising Authority Midwifery Officer for Northern Ireland*

Sara Wickham RM, MA, BA(Hons), PGCE (A) *Independent Midwifery Lecturer and Consultant*

Julie Wray ONC, RN, RM, ADM, MSc, PGCE (HE) *Lecturer/Research Fellow, School of Nursing, University of Salford*

THE PRACTISING MIDWIFE

Contents

- 4 **Comment** Bring back lying in *Caroline Flint*
- 5 **Editorial and Letters**
- 6 **News**
- 12 **Hyperemesis gravidarum: how midwives can help** *Natalie Farrell* examines the debilitating condition
- 15 **Just a normal disabled mum** Midwives must understand the needs and abilities of all their clients, says *Emma Bowler*
- 17 **Informed consent and the birth plan** The birth plan should be embraced, not feared, argues *Jacqueline Wier*
- 20 **Safety in maternity services: women's perspectives** Negative perceptions may deter women from some ethnic groups, report *Clare Homeyard* and *Anna Gaudion*
- 24 **Rebalancing obstetric and midwifery thinking** The balance of power must change if normal births are to increase, says *Meg Taylor*
- 29 **Good on ya, Trish!** *Wendy Marsh* recalls *Tricia Anderson's* advice
- 31 **'We have work to do'** *Gillian Crossley* reports back from last month's ICM conference...
- 32 **Midwives: the key to a healthy future ...** While *Jennifer Hall* gives an insight into the RCM's AGM
- 33 **SHARING SLEEP WITH BREASTFED BABIES (2)** Research suggests sweet dreams result *Barbara Higham* examines the protective effects
- 37 **The babyfriendly page***
- 38 **STUDENTS AT LARGE (4) Going Dutch: midwifery in the Netherlands** *Jenny Squires, Clare Marshall* and *Catherine McEvilly* report on a European placement
- 39 **THINKING OUTSIDE THE BOX Folic acid: the plot thickens** Supplementation is not without risk, says *Sara Wickham*
- 41 **RESEARCH UNWRAPPED** Breastfeeding method and infant weight gain *Lorna Davies* 'unwraps' a recent paper
- 44 **Reviews**
- 45 **PROFESSIONAL DEVELOPMENT**
- 50 **LAST WORD** Bearing the load for women *Lindsay Reid* describes the midwife's burden BC (Before Car)

* Due to unforeseen circumstances The babyfriendly page was omitted from the June issue. Apologies for the error.



NO FORMULA MILK ADVERTISEMENTS

The Practising Midwife is committed to responsible advertising of services and products that will benefit midwife, mother and child. We do not advertise infant formula.



When you have finished with this magazine please recycle it.

Hyperemesis gravidarum: how midwives can help



Research has shown that early, aggressive intervention is important if severe nausea and vomiting during pregnancy is to be controlled, says **Natalie Farrell**

The term nausea and vomiting during pregnancy (NVP) is used to describe a continuum of mild morning sickness to severe illness that is hyperemesis gravidarum (HG). This is defined as a 'debilitating and potentially life-threatening pregnancy disease marked by rapid weight loss, malnutrition, and dehydration due to unrelenting nausea and/or vomiting with potential adverse consequences for the newborn(s)' (MacGibbon 2006).

Research has shown that it is a complex and multifaceted physiological disease and is not, as many have been taught, a psychological illness (Simpson et al 2001, Munch 2002). It affects anywhere between 0.3-2 per cent of pregnancies and has no known cause. There are, however, numerous theories regarding the aetiology of HG – eg, hormone levels (Murphy Goodwin 2000) and genetics (Fejzo et al 2006), to name but two. The likelihood is that it is caused by multiple factors rather than one single factor.

The criteria used to diagnose HG and its severity varies among health professionals and researchers, which results in the term 'Hyperemesis' being applied to a wide spectrum of nausea and vomiting. The symptoms of HG typically involve unrelenting, excessive nausea and/or

vomiting which prevents adequate intake of food and fluids (MacGibbon 2006). It almost always begins in the first trimester between weeks four and six, involving many vomiting episodes throughout the day with few, if any, symptom-free periods. This leads to rapid and significant weight loss, dehydration, electrolyte disturbances and nutritional deficiencies – often requiring hospitalisation.

Typically, symptoms peak between nine to 13 weeks' gestation, with improvement by the 14th-20th week of gestation irrespective of severity (Moran and Taylor 2002), although some women have frequent relapses throughout pregnancy. Some women will find that nausea and vomiting requires some degree of management until the birth, but is usually less severe than in the first trimester. Although rare, a very small number of women suffer from HG starting in the second trimester.

HG is not regular NVP or morning sickness, both of which refer to mild nausea and vomiting during pregnancy. Research shows that, unlike morning sickness, HG has a high rate of recurrence (Koren and Maltepe 2004).

Comparisons between mild NVP/morning sickness and HG are shown in Table 1.

If midwives are quick to identify the signs and symptoms of HG and refer the woman to the appropriate medical practitioner, it will benefit her physiologically and psychologically

dehydration, preventing life-threatening complications and promoting quicker recovery (Koren and Maltepe 2004). Second, do not underestimate how great the impact of HG is on sufferers, their families and friends. If midwives are quick to identify the signs and symptoms of HG and refer the woman to the appropriate medical practitioner, it will benefit her physiologically and psychologically.

Simple measures could include:

- Reduce stimuli and triggers as far as possible – eg, lighting and noise levels, odours, motion and interruptions to rest.
- Listen: loneliness and isolation may well have featured heavily during the course of the illness.
- Watch for signs of psychological illness and refer for assessment as appropriate.
- If possible, refer to a physiotherapist to minimise the effects of atrophy.
- Ask for permission to discuss food and before mentioning food names.
- Ascertain the level of sickness by asking what foods and drinks have been tried, what has helped/what has not.
- Be careful if recommending morning sickness cures to an HG sufferer; she will have been told innumerable times to try crackers and ginger. It may undermine confidence in the healthcare professional.
- Do not challenge what she is or is not eating/drinking; anything is better than nothing.
- Refer to HER (Hyperemesis Education & Research) or Blooming Awful (details in 'Further resources') for a list of foods,

AnaWiz
Prenatal & Infant Healthcare Specialists

- Fetal Dopplers from £94.95 incl VAT
- TENS Machines
- Breast Pumps
- Full range of pre & postnatal products

VISIT [WWW.ANAWIZ.COM](http://www.anawiz.com) OR CALL 0845 6037214

How can midwives help?

There are many ways in which midwives can help. The first thing to remember is that research has shown that early intervention with aggressive management is important for a number of reasons: decreasing severity of symptoms, preventing the continued cycle of vomiting and

TABLE 1 Comparisons between mild NVP/morning sickness and hyperemesis gravidarum

Morning sickness	Hyperemesis gravidarum
Lose little if any weight.	Lose 5% (or more) of pre-pregnancy weight.
Nausea and vomiting does not interfere with ability to eat/drink enough each day.	Nausea and vomiting causes very little, if anything, to be eaten/drunk; dehydration common if not treated.
Vomit infrequently; nausea is episodic but not severe. It may cause discomfort and misery.	Vomit often; may vomit bile or blood if not treated. Nausea is usually severe and constant.
Dietary and/or lifestyle changes are enough to improve symptoms most of the time.	Will probably require medications to stop the vomiting, and intravenous hydration. In severe cases supplemental nutrition may be required.
Typically, will improve gradually after the first trimester; may be a little queasy at times during the remainder of pregnancy.	Usually feel somewhat better by mid-pregnancy; may continue to be nauseous and/or vomit until the birth.
May lose an average of 0-3 weeks of employment and/or use sick time. Job performance may be reduced.	Often is unable to work for months and, in some cases, for the remainder of the pregnancy.
Can perform most household responsibilities, including caring for the family at some point during the day or week when symptoms are less intense.	May be unable to perform even simple household chores. May need to be cared for.
Fatigue is mild to moderate and decreases workload; recumbent rest is needed to alleviate symptoms.	Fatigue may be severe for weeks or months; bed rest is often a necessity. Prolonged fatigue is very common.
Relationships may be stressed but social functioning, if curtailed, is temporary.	Relationships are often greatly strained and family relationships may dissolve; isolation is common and may lead to depression.
Psychological stress is mild and is unlikely to result in depression.	Psychological stress is typically moderate to severe; increased risk of antenatal anxiety and depression and postnatal depression and Post Traumatic Stress Disorder.
Postnatal recovery is typical and usually takes a few months.	Postnatal recovery is prolonged, averaging 6 months – 2 years.

drinks and vitamins that may work.

- Watch for signs of dehydration; refer for medical assessment as appropriate.
- Alleviate any guilt and reassure the mother if she has been unable to take prenatal vitamins.
- Remind her to take the pregnancy a day at a time and that the HG will end.
- Remember that pregnancy sickness is not always a 'good sign'. There are many cases of women whose HG has continued despite later discovering that the fetus died weeks earlier. Unpublished evidence has shown that women with HG are more likely to suffer fetal demise (see www.hyperemesis.org/HER-Research).
- Encourage appropriate medication.
- Those with prolonged illness and inadequate medical care – eg, those with greater than 10 per cent loss of pre-pregnancy body weight or those who fail to gain weight for two consecutive trimesters – are at increased risk of serious complications such as pre-eclampsia and pre-term labour. A referral

should be made to an obstetrician or assessment unit to check for signs of Intra Uterine Growth Retardation.

- Remember that recovering from HG takes time and that there may be a long-term impact on both mother and baby.

Medications

There is always a risk with any medication taken during pregnancy. Medications prescribed during pregnancy typically present less risk to the mother and child than chronic dehydration/lack of nutrition (Dodds et al 2006). Research has been carried out on the teratology of some medications used during pregnancy (Kallen 1987, Berkovitch et al 2002, Einarson et al 2004, Seto et al 1997). Doctors will often treat HG with medications deemed 'safe' to use in pregnancy due to their long history of being used for pregnancy nausea and vomiting.

To treat a sufferer of HG, typically a combination of several medications is most effective (Levichek et al 2002, Einarson et al

2007). It is important to remember that a certain combination of medications may help one sufferer but not the next. Combinations can include standard anti-emetics, antihistamines, antacid medications, complementary or alternative medicines and nutritional therapies. Thiamine and multivitamin supplementation are critical for a mother who has vomited excessively for more than a few weeks to prevent life-threatening complications. Psychotherapy may be effective for secondary psychological complications.

Termination

An article about HG would be incomplete without discussing therapeutic termination. If requested by the sufferer, it is often a cry of desperation for help and for better management. For HG sufferers, therapeutic termination rates are approximately 25 per cent. A significant proportion cite lack of understanding by their healthcare professional as a factor (Poursharif et al ►

Hyperemesis gravidarum: how midwives can help

2007, Mazzota et al 1997). Termination in most cases of HG is avoidable with aggressive use of the available treatment options, and should always be a last resort. The long-term consequences of termination of a usually much wanted child cannot be overlooked or underestimated (Mazzota et al 1997). **TPM**

Natalie Farrell is a moderator for the Hyperemesis Education & Research Foundation and two-times HG survivor.

Acknowledgements

Thanks to the Hyperemesis Education & Research Foundation for the use of information on its website. Also to Dr Sarah Jones (HER), Aimee Brecht-Doscher MD (HER) and Johanne Jakeway (Blooming Awful) for reviewing the medical content of this article.

FURTHER RESOURCES

● The Hyperemesis Education & Research Foundation (HER) (www.hyperemesis.org) is a non-profit organisation that has a website containing comprehensive information for health professionals, sufferers and survivors of HG with busy discussion forums. A volunteer system is in place.

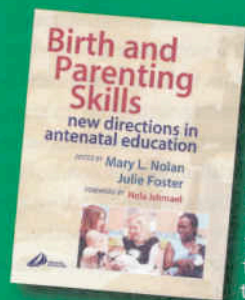
● Blooming Awful (www.hyperemesis.org.uk), the HG awareness group in the UK, is run by midwife Johanne Jakeway. Helpline: 01656 863883.

● Beyond Morning Sickness (BMS) (www.beyondmorningsickness.com) is a website and forum for HG sufferers and survivors based on the first comprehensive book on HG, *Beyond Morning Sickness: Battling Hyperemesis Gravidarum* by Ashli Foshee McCall. BMS is not for profit, and all monies raised go directly to helping those suffering from HG.

REFERENCES

- Berkovitch M, Mazzota P, Greenberg R et al (2002). 'Metoclopramide for nausea and vomiting of pregnancy: a prospective multicenter international study'. *American Journal of Perinatology*, 19 (6): 311-316.
- Dodds L, Deshayne B, Joseph KH et al (2006). 'Outcomes of pregnancies complicated by hyperemesis gravidarum'. *Obstetrics & Gynecology*, 107 (2 pt 1): 285-292.
- Einarson A, Maltepe C, Boskovic R and Koren G (2007). 'Treatment of nausea and vomiting in pregnancy: an updated algorithm'. *Canadian Family Physician*, 53 (12): 2109-2111.
- Einarson A, Maltepe C, Navioz Y et al (2004). 'The safety of ondansetron for nausea and vomiting of pregnancy: a prospective comparative study'. *BJOG: An International Journal of Obstetrics and Gynaecology*, 111 (9): 940-943.
- Fejzo M S, Ingles M, Wilson W et al (2006). 'Familial aggregation of hyperemesis gravidarum'. *American Journal of Obstetrics and Gynecology*, 195 (6): 5191.
- Kallen B (1987). 'Hyperemesis during pregnancy and delivery outcome: a registry study'. *European Journal of Obstetrics and Gynecology and Reproductive Biology*, 26 (4): 291-302.
- Koren G and Maltepe C (2004). 'Pre-emptive therapy for severe nausea and vomiting of pregnancy and hyperemesis gravidarum'. *Journal of Obstetrics and Gynaecology*, 24 (5): 530-533.
- Levichek Z, Atanackovic G, Oepkes D et al (2002). 'Nausea and vomiting of pregnancy. Evidence-based treatment algorithm'. *Canadian Family Physician*, 48: 267-8, 277.
- MacGibbon K (2006). Hyperemesis Education and Research Foundation website www.hyperemesis.org (accessed 29-5-08).
- Mazzota P, Magee L and Koren G (1997). 'Therapeutic abortions due to severe morning sickness; an unacceptable combination'. *Canadian Family Physician*, 43: 1055-1057.
- Moran P and Taylor R (2002). 'Management of hyperemesis gravidarum: the importance of weight loss as a criterion for steroid therapy'. *Quarterly Journal of Medicine*, 95: 153-158.
- Munch S (2002). 'Chicken or the egg? The biological-psychological controversy surrounding hyperemesis gravidarum'. *Social Science and Medicine*, 55 (7): 1267-78.
- Murphy Goodwin T (2000). 'Human chorionic gonadotropin and hyperemesis gravidarum in nausea and vomiting of pregnancy', in G Koren and R Bishai (eds), *State of the Art 2000, Motherisk*.
- Poursharif B, Korst LM, MacGibbon KW et al (2007). 'Voluntary termination in a large cohort of women with hyperemesis gravidarum'. *Obstetrics and Gynaecology*, 109 (4): 133-146.
- Seto A, Einarson T and Koren G et al (1997). 'Pregnancy outcome following first trimester exposure to antihistamines: meta-analysis'. *American Journal of Perinatology*, 14 (3): 119-24.
- Simpson SW, Goodwin TM, Robins SB et al (2001). 'Psychological factors and Hyperemesis Gravidarum'. *Journal of Women's Health and Gender Based Medicine*, 10 (5): 471-7.

Book of the month



This month we are giving away a copy of *Birth and Parenting Skills: New Directions in Antenatal Education* by Mary Nolan and Julie Foster (2005, Churchill Livingstone, £23.99, pbk).

This is a research-based, up-to-the-minute account of the current status of antenatal education, focusing on the key challenges it faces in the future, offering suggestions for how these challenges might best be met. It

describes some innovative approaches to accessing vulnerable groups of parents and how collaboration between the statutory and voluntary sectors might result in a better educational service for pregnant women and their families. Narratives from parents are analysed and commented upon, and underpinning the book is an account of how the principles and practices of adult education should inform antenatal education.

To enter, email L.McGill@elsevier.com or write your name and address on the back of a postcard or sealed envelope and send to:

Leanne McGill, TPM (0708) prize draw, Health Professions Marketing, Elsevier, 32 Jamestown Road, London NW1 7BY. Closing date: **Friday 7 August**

MAY WINNER: Charlotte Clayton, Northants