

Early pregnancy complications

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Abstract

The early pregnancy period can be complicated by a range of symptoms varying from nausea, vomiting, vaginal spotting and pelvic pain, to more severe conditions such as hyperemesis gravidarum, early embryonic demise, mental health problems and either molar or ectopic pregnancies. Some of these conditions require hospital admission and multidisciplinary team management, whilst others can be managed in an outpatient setting after the appropriate investigations. Complications early on in the pregnancy can be distressing, therefore women who experience such symptoms require close monitoring, reassurance and information on how to access help. Early pregnancy units have been specifically designed to serve patients with complications in early pregnancy and the health professionals are trained to support women during their treatment, whilst helping these patients make informed decisions about their care. This review summarises the key presentations, investigations and management of the most common complications that can arise in early pregnancy.

Keywords early embryonic demise; early pregnancy; ectopic pregnancy; hyperemesis gravidarum; molar pregnancy

Introduction

Early pregnancy, or the first trimester, begins on the first day of the woman's last period and lasts until the end of the 12th week. Most women are aware of pregnancy-associated symptoms during this period and prior to confirmation of conception. Tiredness, breast tenderness, nausea and mood swings are some of the most common early signs that appear in the first trimester of pregnancy. Other symptoms can also present in the first 12 weeks but can be more severe and require close monitoring and quick and efficient treatment. The most common early pregnancy complications are:

- a. Hyperemesis gravidarum
- b. Early embryonic demise and ectopic pregnancy
- c. Molar pregnancy
- d. Ovarian hyperstimulation syndrome
- e. Ovarian accidents
- f. Urinary tract infection
- g. Abnormal vaginal discharge

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h. Unplanned pregnancy occurred while using contraception/intrauterine devices.

i. Mental health problems

This review summarises each of these key presentations, expanding on investigations and management for each.

Hyperemesis gravidarum

Hyperemesis gravidarum (HG) is defined as protracted vomiting associated with a triad of weight loss of over 5%, dehydration and electrolyte imbalance (e.g. hyponatraemia, hypokalaemia and hypochloraemia). It can be diagnosed using the Pregnancy-Unique Quantification of Emesis (PUQE) score (Table 1). This form of severe nausea and vomiting in pregnancy affects about 0.3–3.6% of pregnant women, whilst recurrence rates vary. It usually starts between the fourth and seventh week of gestation with a peak between the ninth and tenth week, with 90% of cases resolving by 20 weeks. If initial onset is after 10 + 6 weeks gestation, other causes need to be ruled out. HG is primarily thought to be associated with rising beta-hCG levels, with more severe cases seen in trophoblastic disease and multiple pregnancy where the hormone level is also very high.

One hospital admission for HG is estimated to cost £470 per day. The average length of hospital stay is 3.5 days. It is estimated that NHS funds diverted to treat hyperemesis can reach £36,481,745 a year.

This doesn't include the cost of the appointments with midwives or GP prior to admission

Ref: Statement on the cost of hyperemesis. <https://www.pregnancysicknesssupport.org.uk/resources/literature-review/hyperemesis-gravidarum-9/>

Baseline assessment includes;

- a thorough history of nausea or vomiting in pregnancy or HG, the use of the PUQE score, and exclusion of other causes of the symptoms (urinary infections, drug history etc);
- examination for signs of dehydration, basic observations using the MEWS chart, abdominal palpation and patient weight plus BMI. Urine dipstick analysis – with an MSU if required.
- bloods, including urea and electrolytes to assess for electrolyte imbalance, dehydration and renal disease, a full blood count to assess the risk of infection and anaemia and blood glucose if diabetic (to help rule out diabetic ketoacidosis).
- ultrasound scan to confirm viability of pregnancy, or to diagnose multiple pregnancy or trophoblastic disease.

Patients with recurrent admissions require thyroid tests, liver function tests, calcium and phosphate testing, amylase and an arterial blood gas.

Ideally women with nausea and vomiting but without dehydration should be managed in the community with oral anti-emetics, reassurance and advice on oral hydration and diet. If this fails and the PUQE score is less than 13, ambulatory daycare management can be implemented to provide parenteral fluids, vitamins such as the B-complex, and anti-emetics. This regime has been shown to improve symptoms in up to 90% of cases.

PUQE-24 score: Mild ≤ 6, Moderate = 7–12, Severe = 13–15**Motherisk PUQE-24 scoring system**

In the last 24 hours, for how long have you felt nauseated or sick to your stomach	Not at all (1)	1 hour or less (2)	2–3 hours (3)	4–6 hours (4)	More than 6 hours
In the last 24 hours have you vomited or thrown up?	7 or more times (5)	5–6 times (4)	3–4 times (3)	1–2 times (2)	I did not throw up (1)
In the last 24 hours how many times have you had retching or dry heaves without bringing anything up?	No time (1)	1–2 times (2)	3–4 times (3)	5–6 times (4)	7 or more times (5)

Table 1

When pregnancy is complicated by HG, in-patient treatment should be provided. The criteria used for admission of women with hyperemesis are:

- Inability to keep down any medication or anti-emetics,
- Associated comorbidities such as urinary tract infections,
- constant nausea and vomiting with ketonuria, and/or weight loss of more than 5%, despite anti-emetics

Medical treatment includes anti-emetics, antacids, thiamine and folic acid supplements, thromboprophylaxis and intravenous fluids. Normal saline and potassium chloride are used for rehydration as most women are hyponatraemic, hypochloaemic, hypokalaemic and ketotic. Dextrose can precipitate Wernicke's encephalopathy, therefore this is only appropriate if thiamine has been administered and sodium levels are normal.

First-line anti-emetics are antihistamines and phenothiazines, while second line therapies include metoclopramide (due to the risk of extrapyramidal side effects) and ondansetron (due to limited data available). Corticosteroids are used only for resistant cases of hyperemesis where all the other treatments have failed (100 mg intravenous hydrocortisone twice-daily, then oral prednisolone 40–50 mg daily once clinical improvement occurs, with the dose gradually tapered by 10 mg every 2–3 days until the lowest maintenance dose that controls symptoms is reached). Typically prednisolone will need to be continued at the lowest maintenance dose until the gestational age where symptoms generally resolve, but in extreme cases this may be till delivery. Thiamine is administered to all women with hyperemesis to reduce the risk of Wernicke

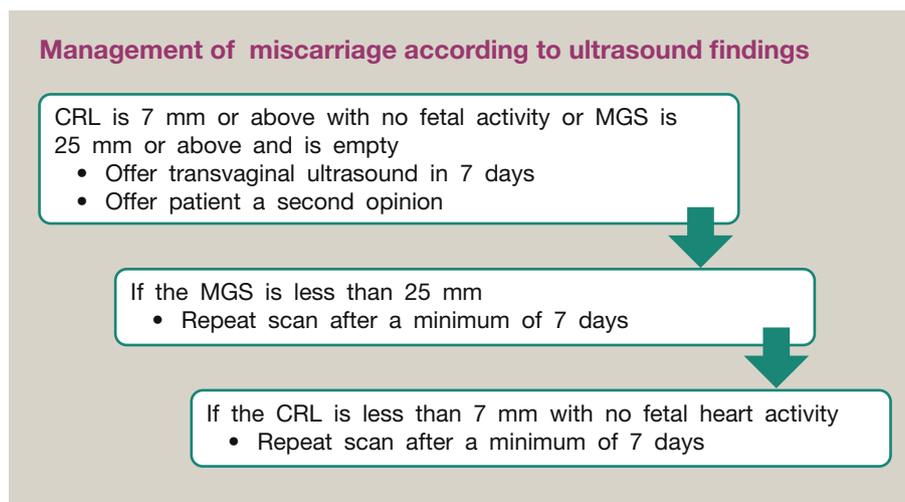
encephalopathy. Associated gastro-oesophageal reflux is managed with histamine H₂ receptors antagonists or proton pump inhibitors.

Thromboprophylaxis with low molecular weight heparin is indicated in hyperemesis where patients are admitted, and oral iron supplements should be avoided in cases of severe nausea and vomiting as they can exacerbate symptoms.

Patients who want to avoid medical therapies can consider the use of ginger in mild to moderate nausea and vomiting. Studies have shown that it reduces symptoms compared with placebo therapies, although inferior to metoclopramide. Acupressure may also improve symptoms and is safe in pregnancy. In complicated cases of hyperemesis, where all medical treatments have failed, enteral or parenteral approaches can be considered; in severe cases, the option of termination of pregnancy should be discussed with the patient. Patients who continue to have sickness in the second trimester should be offered regular antenatal appointments and fetal growth scans. All these women need a multidisciplinary approach to manage and support them.

Early embryonic demise and ectopic pregnancy

Although vaginal bleeding is associated with a 20% risk of miscarriage, it can also be a sign of molar or ectopic pregnancy. Diagnostic transvaginal ultrasound scan should be offered to all pregnant women who present with vaginal bleeding and are haemodynamically stable. The diagnosis of early embryonic demise is made using the crown rump length (CRL) and mean gestation sac (MGS) measurements on the ultrasound scan as shown in [Figure 1](#).

**Figure 1** Management of miscarriage according to ultrasound findings.

Terminology in early pregnancy

Terminology	Vaginal bleeding	Vaginal findings	Scan findings
Threatened miscarriage	Present	Cervical os closed	Normal
Inevitable miscarriage	Present	Cervical os open	Normal/short cervix
Incomplete miscarriage	Present	Cervical os closed/open	Retained product of conception
Complete miscarriage	Absent	Cervical os closed	Empty uterine cavity

Table 2

A written report should be issued to the patient following her consultation. This should state the clinical findings, the diagnosis (Table 2), investigation results and a clear management plan.

Women with vaginal bleeding and a viable intrauterine pregnancy on scan need to be advised that if her bleeding worsens or persists for more than 14 days, she should return for further assessment. If the bleeding ceases then she should start or continue antenatal care.

After the cause of bleeding is established as early embryonic demise in the first trimester, the treatment options should be discussed with the patient. Expectant management should be offered as the first-line treatment option for 7–14 days where there is no increased risk of haemorrhage, previous adverse experience with pregnancy, history of coagulopathies or evidence of infection. Women should be provided with oral and written information on what to expect and how to get help in case of an emergency. If the bleeding and pain stops within the 7–14 days this suggests a complete miscarriage and the woman should be advised to take a urinary pregnancy test after 3 weeks and return if it is positive. A repeat scan is offered if pain or bleeding has not started after 7–14 days or if the symptoms persist beyond this time indicating an incomplete miscarriage.

Medical management should be offered to women if expectant management is not acceptable. The standard misoprostol regime includes 800 µg vaginally, or orally if preferred, for a missed miscarriage or 600 µg for an incomplete miscarriage. Women should seek advice if bleeding has not started 24 hours after treatment. Information should also be given on what to expect, side effects and when to seek help. A urinary pregnancy test should be taken after 3 weeks and the woman should be advised to contact the hospital if it remains positive.

Surgical management includes manual vacuum aspiration under local anaesthetic in an outpatient setting or in theatre under general anaesthetic. Post treatment advice should again be clearly given with contact details in case of an emergency, Anti D 250 UI/L should be given to all rhesus negative women undergoing a surgical intervention.

An ectopic pregnancy is defined as embryonic implantation outside the uterine cavity in either the fallopian tube, ovary, interstitial portion, caesarean section scar or myometrium. In the UK the incidence of ectopic pregnancies is 11/1000 with approximately 11,000 diagnosed every year. The risk factors for ectopic pregnancy include tubal damage, previous tubal surgery, previous pelvic infection, endometriosis and previous ectopic pregnancy.

The main symptoms of an ectopic pregnancy are pelvic, adnexal and abdominal pain, vaginal bleeding, shoulder-tip pain, gastrointestinal and urinary symptoms. The management is

based on the clinical picture, ultrasound findings and patient discussion and consent.

Medical management using methotrexate is offered as first-line if the patient is asymptomatic and haemodynamically stable, with an un-ruptured ectopic mass less than 35 mm without a visible heartbeat and no intrauterine pregnancy. The bHCG levels should also be less than 1500 IU/litre. The healthcare professional should be sure that the patient will be compliant with the management plan. It is essential that bHCG is monitored on day 4 and 7, and then weekly until levels are undetectable. If the levels of serum HCG are not decreasing by more than 15% between day 4 and 7 then a second dose of methotrexate is recommended.

Surgical management is the preferred treatment if any of the criteria for medical management is not met or if they have a serum hCG level of 5000 IU/litre or more, or the woman chooses to have surgery. A choice of medical or surgical options can be given if the serum hCG levels are between 1500 and 5000 IU/litre, and all the other criteria for medical management is met.

Laparoscopic salpingectomy is the surgical option of choice unless the woman has risk factors for infertility. The patient should be advised to take a urinary pregnancy test 3 weeks after the procedure and return if the test remains positive. Laparoscopic salpingotomy is preferred in patients with previous contralateral tubal damage who wish to preserve fertility. Patients are advised that this option has a failure rate of 20%. It is recommended that bHCG levels are measured 7 days after the procedure, and then weekly until a negative result is obtained.

Pregnancy of unknown location is diagnosed when the urine pregnancy test is positive but there is no evidence of intrauterine or extra-uterine pregnancy on the scan. Management involves commitment to a clear algorithm as shown in Figure 2.

“The rate of ectopic pregnancy is 11 per 1000 pregnancies, with a maternal mortality of 0.2 per 1000 estimated ectopic pregnancies (Cantwell et al. 2011). Medical management of ectopic pregnancy with methotrexate costs £613, while laparoscopic surgery is estimated to £2313 and laparotomy is estimated to £2445. NICE guidelines on cost of ectopic pregnancy - <https://www.nice.org.uk/guidance/cg154/resources/costing-report-188359309>

Molar pregnancy

Molar pregnancies are intrauterine pregnancies characterised by abnormal trophoblast proliferation and may present with vaginal bleeding and severe hyperemesis in early pregnancy. The incidence of a molar pregnancy is 1:714.

bHCG monitoring: diagnosis and management in pregnancies of unknown location

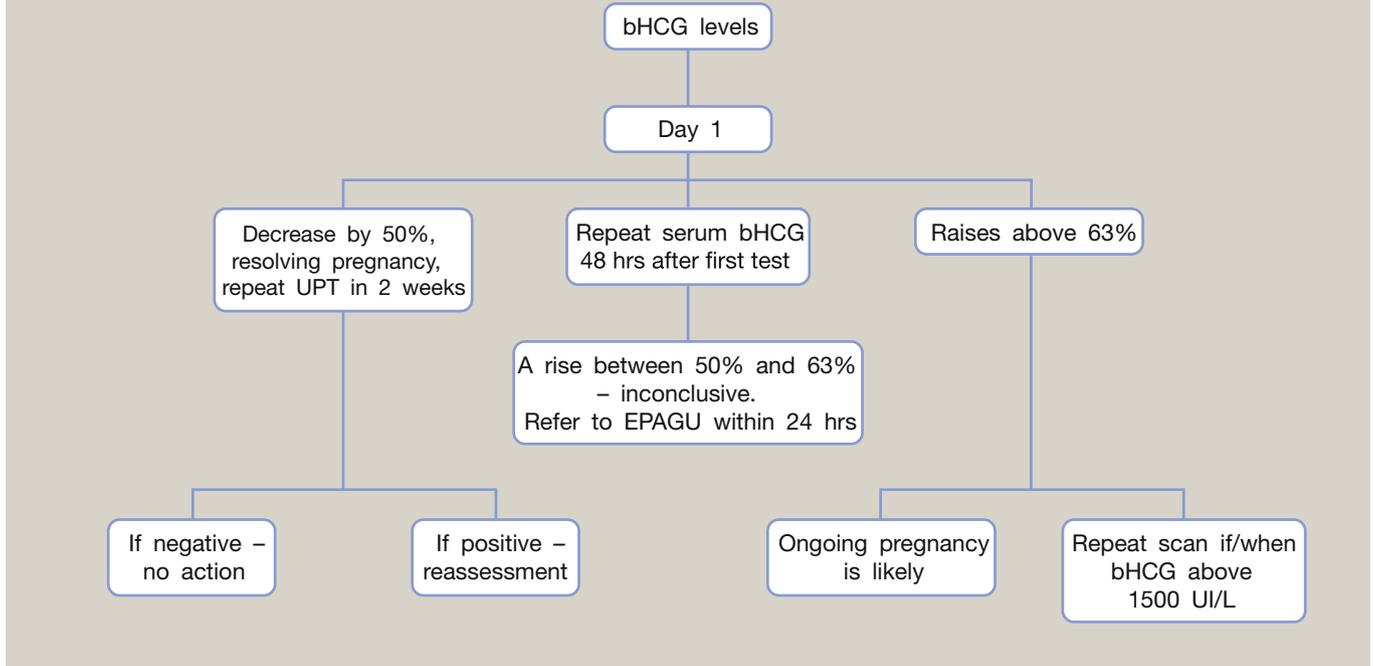


Figure 2 bHCG monitoring: diagnosis and management in pregnancies of unknown location.

Molar pregnancies are classified as:

- Complete molar
- Partial molar
- Invasive molar
- Choriocarcinoma
- Placental site trophoblastic tumour

Table 3 details the characteristics of complete and partial molar pregnancies. The clinical presentation of molar pregnancy includes symptoms such as vaginal bleeding, abnormally enlarged uterus for the gestation and severe hyperemesis. On rare occasions, the clinical presentation could include early pre-eclampsia, hyperthyroidism, respiratory insufficiency and neurological signs.

The diagnosis of molar pregnancy is strongly suggested by ultrasound and later must be confirmed by histopathological assessment of the products of conception. Surgical evacuation of the products of conception is recommended as the first-line treatment of molar pregnancies. Once a histopathological diagnosis is made, the patient should be referred to the regional

gestational trophoblastic centre for further management and treatment.

An essential part of the management involves serial bHCG measurements every 2 weeks. If the levels fall to normal values in the first 8 weeks post-evacuation, then the patient's monitoring can stop at 6 months post-surgery. If the levels take longer to fall, then follow up is usually recommended for 6 months from the time when bHCG values first normalised. At this stage the patient can be discharged. It is recommended that a future pregnancy is deferred for one year from the completion of treatment. The risk of recurrence is quoted as approximately 1 in 80.

Ovarian Hyperstimulation Syndrome (OHSS)

OHSS is a complication of fertility treatments which use pharmacological ovarian stimulation to increase the yield of oocytes available during assisted reproductive technology (ART).

OHSS is described as acute if the onset occurs in the first 7 days after the hCG injection, or late if the presentation is after day 10 of fertilisation.

Risk factors for OHSS include:

- previous history of OHSS,
- polycystic ovary syndrome,
- increased antral follicle count (AFC), or high levels of anti-Müllerian hormone (AMH),
- use of GnRH agonists or hCG
- multiple embryo transfer
- higher oocyte yields
- greater counts of mature follicle development prior to egg collection

While avoiding the variable risk factors above (such as the use of GnRH antagonists instead of agonists) may decrease the

Characteristics of molar pregnancies

Partial molar pregnancies

- Genetically triploid
- Results from fertilisation of an ovum by two spermatozoa
- Contain fetal parts

Complete molar pregnancy

- Genetically diploid
- Result from fertilisation of an empty ovum by one spermatozoa
- Absent fetal parts

Table 3

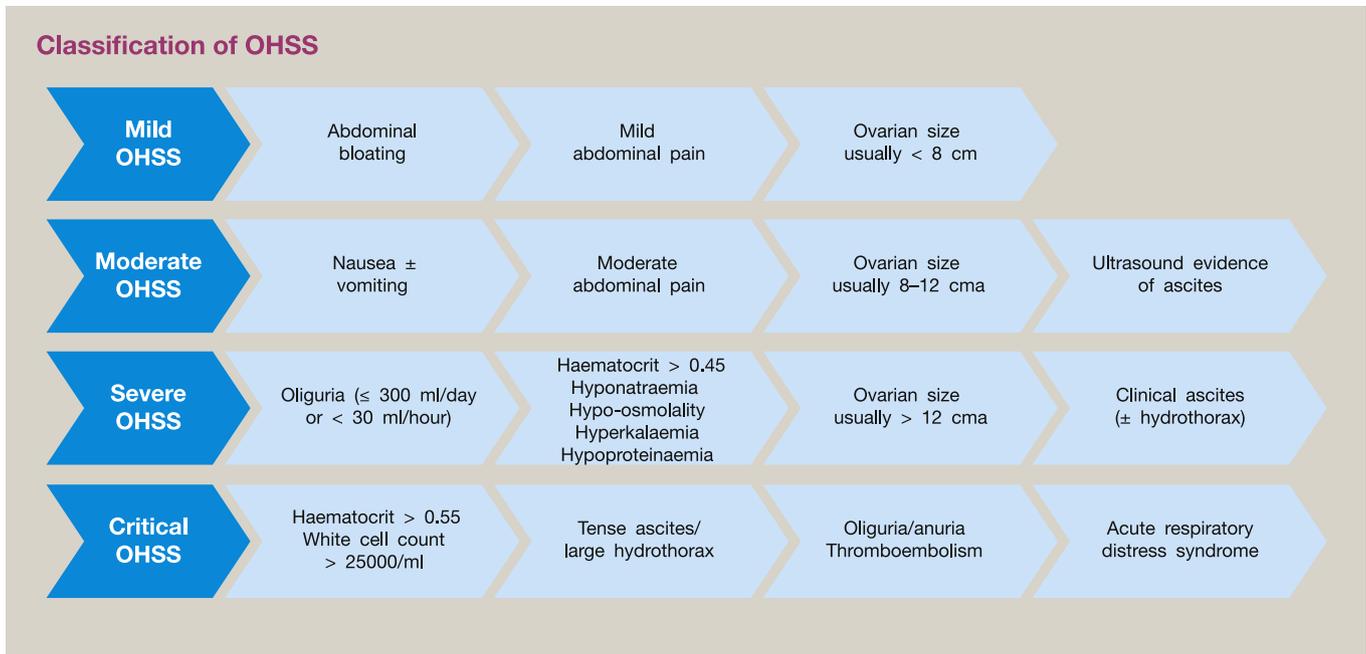


Figure 3 Classification of OHSS.

incidence of OHSS, the syndrome can still occur in patients that do not meet any of the criteria deemed 'high-risk'. The incidence of OHSS is also higher in cycles where conception occurs compared with regimes where conception does not, and in even higher in multiple pregnancy, highlighting the role of endogenous hCG.

The management of OHSS should be guided by the severity, and is dealt with in greater detail in The Management of Ovarian Hyperstimulation Syndrome, Green-top Guideline No.5, published February 2016. [Figure 3](#) summarises the classification of OHSS and [Table 4](#) sets out the key investigations.

Symptoms of OHSS should be managed with adequate analgesia and antiemetics, while being careful to avoid medication contraindicated in pregnancy. Paracetamol and opiates are commonly used. Oral fluid replacement according to thirst is the most appropriate way of correcting intravascular dehydration. Women should be advised to drink at least 1 L a day. Urine output of less than 1 L per 24 hours or a positive balance of more

than 1 L over 24 hours requires prompt review of severity. This highlights the importance of strict fluid balance charts in an outpatient and inpatient setting. Women with ongoing haemoconcentration despite intravenous colloid replacement may need invasive monitoring and anaesthetic input.

OHSS is a prothrombotic state due to haemoconcentration and vascular endothelial dysfunction. Women with OHSS who are managed as outpatients, should be assessed for thromboprophylaxis requirement and prescribed compression stockings or low molecular weight heparin (LMWH) as required. The incidence of thromboembolic events in assisted conception pregnancies varies between 0.7% and 10%. The rate of thromboembolic events is 0.8:1000 for IVF pregnancies compared with 0.2:1000 for those that have spontaneously conceived.

Paracentesis is considered when there is severe abdominal distension with associated shortness of breath and oliguria. NSAIDs and diuretics should be avoided as these could affect renal function. All patients with OHSS should be informed of the risk of pre-eclampsia and preterm delivery.

Ovarian accidents in pregnancy

Approximately 80–95% of all adnexal masses in pregnancy represent functional cysts which carry a very low risk of malignancy and are expected to resolve spontaneously by the end of the first trimester. If an ovarian cyst is still present beyond 12 weeks' gestation a different underlying pathology becomes more likely, such as a cystic mature teratoma. The incidence of ovarian masses in pregnancy is 2%. Conservative management is recommended in ovarian cysts with a diameter below 6 cm with no malignant features and negative tumour markers. Acute ovarian accidents are treated surgically.

Overall, 10–15% of ovarian masses undergo torsion and the diagnosis is confirmed intra-operatively. If diagnosed early, detorsion of the twisted ovary may be successful. Late diagnosis can be complicated by peritonitis and spontaneous miscarriage.

Recommended investigations in OHSS

- Full blood count
- Haematocrit
- C-reactive protein (severity)
- Urea and electrolytes (hyponatraemia and hyperkalaemia)
- Serum osmolality (hypo-osmolality)
- Liver function tests (elevated enzymes and reduced albumin)
- Coagulation profile (elevated fibrinogen and reduced antithrombin)
- hCG (to determine outcome of treatment cycle) if appropriate
- Ultrasound scan: ovarian size, pelvic and abdominal free fluid. Consider ovarian Doppler if torsion suspected

Table 4

It is rare for ovarian cysts to be operated on during pregnancy unless they are symptomatic or there is a high level of concern about the possibility of an underlying malignancy. Persistent ovarian cysts do require a follow up plan post-birth however.

Urinary tract infections (UTI)

Pregnancy predisposes to urinary tract infection due to the gravid uterus applying pressure on the bladder and hormonal changes reducing smooth muscle tone, both of which cause relative urinary stasis. Bacterial colonisation of the urethra may occur secondary to sexual intercourse, urinary incontinence or poor personal hygiene. Asymptomatic bacteriuria left untreated increases the risk of developing symptomatic urinary tract infections by four times. In pregnancy, this is associated with an increased risk of premature rupture of membranes, premature labour and low birth-weight. The most common causative organism is *Escherichia coli*, occurring in 90% of cases.

It is recommended that asymptomatic bacteriuria and symptomatic UTI both receive antibiotic treatment in pregnancy. Prior to commencing treatment, one sample of urine should be sent for microscopy, culture and sensitivity testing. The antibiotic chosen should be decided by local guidelines and the results of sensitivity testing on a urine culture. Repeated urinary tract infections during pregnancy should prompt consideration of a renal tract ultrasound scan.

Bacterial vaginosis in pregnancy

In some populations, as many as 12% of all antenatal patients have been diagnosed with bacterial vaginosis on vaginal swabs, or on clinical picture alone. In pregnancy, bacterial vaginosis is associated with late miscarriage, preterm birth, preterm premature rupture of membranes, and postpartum endometritis. Pregnant women with bacterial vaginosis should be treated with either oral or topical low-dose metronidazole. Oral metronidazole 400 mg or 500 mg twice daily is the treatment of choice for symptomatic patients. For women who prefer topical treatment, metronidazole gel 0.75% mg once a day for 5 days can be prescribed. Testing should be repeated after 1 month if the woman is still symptomatic.

Unplanned pregnancy occurring while using contraception/intrauterine devices (IUD)

If a pregnancy occurs with an IUD in situ, removal should be considered before 12 weeks of gestation in order to reduce the risk of miscarriage, preterm labour and infection. The incidence of pregnancy with the progesterone intrauterine device is 0.2% (1:500) and 0.8% (1:125) for the copper coil. More than half of all pregnancies which have developed with an IUD in situ, will result in miscarriage and approximately 6% of the pregnancies will be ectopic. If the threads are visible at vaginal examination then the coil/intrauterine device should be removed before 12 weeks' gestation. If the threads are not visible then confirmation of the coil should be sought at delivery or at the time of termination of pregnancy. Ultimately a pelvic x-Ray is helpful in diagnosing an extra-uterine coil.

Mental health problems in pregnancy

The majority of women have good mental health throughout pregnancy. Some women may have a past history of mental

health issues or be on treatment for mental health problems when they become pregnant, whilst others have mental health problems for the first time in pregnancy.

Pre-existing mental illness can be exacerbated in early pregnancy due to the changes and uncertainties this time brings. Women who are on treatment often worry that the medication will affect the development of the baby and cease to continue it once they find out that they are pregnant. However, 7 of every 10 women who stop antidepressants in early pregnancy become unwell again. Education during the preconceptional period, regarding the relative safety of most treatments during pregnancy, may help to prevent unsupervised cessation of psychotropic medications during early pregnancy.

Depression and anxiety are the most common health problems that present, affecting 10–15 % of pregnant women. Symptoms during pregnancy are similar to those occurring with mental illness outside of pregnancy. However, they can be confused with pregnancy-related presentations, e.g. broken sleep or lack of energy. When a woman first presents to primary care or at her booking visit in the first trimester, depression identification questions will help identify women at risk of mental health issues in pregnancy. Other questionnaires such as the GAD-2 scale can also be implemented for anxiety identification. Women with mental health problems in pregnancy require information, support and advice from early pregnancy, whilst also supporting the family. A multidisciplinary approach is vital in managing these women and their families while providing adequate monitoring and increased contact with them. Non-pharmacological interventions include self-help management and CBT. If a woman who is taking TCA, SSRI or SNRI's for anxiety becomes pregnant, discussion needs to be made regarding stopping the medication gradually and switching to high-intensity CBT, or continuing the medication if she understands the risks associated. If presenting with moderate or severe depression in pregnancy, high-intensity psychological intervention like CBT needs to be considered, or medication such as TCA, SSRI or SNRI can be considered if they understand the risks associated. Women with a history of severe depression presenting with mild depression in early pregnancy need to consider TCS, SSRI or SNRI medication. All of the above management discussed needs to be implemented early in the pregnancy, if identified.

Conclusion

Early pregnancy complications can be simple, or far more complex and they require early diagnosis with multidisciplinary input. All healthcare professionals should have an understanding of the common early pregnancy symptoms that require further investigation and management. Access to early pregnancy units and out of hours GP practices has proven to be beneficial, as well as cost-effective. Staff should be compassionate and be specifically trained to break bad news regarding early pregnancy failure and loss. ◆

FURTHER READING

Antenatal and postnatal mental health: clinical management and service guidance. <https://www.nice.org.uk/guidance/cg192>.

Bacterial vaginosis- Clinical Knowledge Summaries <https://cks.nice.org.uk/bacterial-vaginosis-scenario:1>.

British Association of sexual health and HIV <https://www.bashh.org/documents/4413.pdf>.

Ectopic pregnancy and miscarriage: diagnosis and initial management <https://www.nice.org.uk/guidance/cg154>.

Faculty of Sexual and Reproductive Healthcare. Intrauterine contraception. London: FSRH, 2007.

Gestational Trophoblastic Disease (Green-top Guideline No. 38) - RCOG https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_38.pdf.

Guidelines for Diagnosis, Treatment, and Use of Laparoscopy for Surgical Problems during Pregnancy: <https://www.sages.org/publications/guidelines/guidelines-for-diagnosis-treatment-and-use-of-laparoscopy-for-surgical-problems-during-pregnancy/>.

The Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum (Green-top Guideline No. 69): <https://www.rcog.org.uk/globalassets/documents/guidelines/green-top-guidelines/gtg69-hyperemesis.pdf>.

The Management of Ovarian Hyperstimulation Syndrome RCOG guidelines no. 5 https://www.rcog.org.uk/globalassets/documents/guidelines/green-top-guidelines/gtg_5_ohss.pdf.

Trussell J. Contraceptive efficacy. In: Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, Policar M, eds. Contraceptive technology: twentieth revised edition. New York NY: Ardent Media, 2011.

Practice points

- Severe hyperemesis gravidarum requires hospital admission and multidisciplinary team involvement
- Ectopic pregnancies can be managed medically or surgically depending on presentation and test results.
- While under monitoring it is recommended that patients diagnosed with gestational trophoblastic disease should not get pregnant.
- Ovarian hyperstimulation syndrome is more common in IVF pregnancies
- Both asymptomatic and symptomatic urinary tract infections require treatment in pregnancy
- Bacterial vaginosis diagnosed in pregnancy requires treatment
- A multidisciplinary approach is vital in managing mental illness from early on in the pregnancy