

# Women's Health Advisory

News and ideas for you to use from researchers and clinicians at Women & Infants/Brown

Spring/  
Summer  
2009

## It's hot in the Department of Obstetrics & Gynecology

This spring/summer season may be off to a cold, delayed start—but the Department of Obstetrics and Gynecology at Women & Infants/Brown is hot—with so many things happening. If you want to know some of the latest and are a Twitter user, sign up for Gary Frishman's twitter site at [brownobgyn@twitter.com](http://brownobgyn@twitter.com).



The Department is a hotbed of innovation. We have recently started a new program with the Brown students to outreach to Spanish speaking populations about women's health topics with Associate Chair, Dr. Pablo Rodriguez on Latino Public Radio (WELH 88.1FM, [www.lprri.org](http://www.lprri.org)). The program kicked off this spring and is already a smashing success. We continue to enhance the internet services we offer to referring physicians on our website – [www.womenandinfants.org/forphysicians](http://www.womenandinfants.org/forphysicians). We will have selected Grand Rounds up on podcasts for you to enjoy by the fall, as well as new CME opportunities for you to enjoy in the beautiful new South Pavilion of Women & Infants Hospital. More faculty are coming to expand on the preeminence of our already premiere faculty (see the article on Dwight Rouse), and we are expanding our network of subspecialists out into communities to fully support the wonderful community of physicians in Rhode Island, Massachusetts, and Connecticut who are committed to providing the best care for women.

As we move toward the fall, I want to encourage and invite you to join us on tours of the new South Pavilion. This will be the largest, single-family-room NICU in the United States and the most sophisticated inpatient unit for high-risk mothers in our region. It is amazing to have this level of care and expertise so close to home—New England's premiere hospital for women and newborns. We hope you will come visit, get to know us better, and always feel free to call with any questions or to let us know how we can be of help to you!

You'll be receiving an invitation soon for a special "Insider's Sneak Preview" of the South Pavilion. For more information, call (401) 453-7587 or visit [www.womenandinfants.org/insidertour](http://www.womenandinfants.org/insidertour).

**Joanna M. Cain, MD**

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## New Faces

### Women & Infants Welcomes One of the Nation's Top Researchers to Maternal-Fetal Medicine Staff



Women & Infants is pleased to welcome Dwight J. Rouse, MD, MSPH, one of the nation's leading researchers, to our Department of Maternal-Fetal Medicine. Dr. Rouse comes to Providence in September from the University of Alabama. He is the leading researcher and author of the recent paper that examines the use of magnesium sulfate during pregnancy to prevent cerebral palsy. He presently is Professor and Medical Director of the University of Alabama's Obstetric Complications Clinic.

Dr. Rouse earned a bachelor's degree in biology from Harvard College, a medical degree from the University of Illinois, and a master's degree in public health, with a concentration in epidemiology, from the University of Alabama's School of Public Health. He completed his internship and residency at the University of Iowa, and a fellowship in maternal-fetal medicine through the University of Alabama. *(cont'd on page 2)*



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Women & Infants

New England's premier hospital for women & newborns.

# New Faces...

## Women & Infants Welcomes Dr. Rouse (cont'd from page 1)

His niche in the field of maternal-fetal medicine is research into illnesses during pregnancy and establishing networks to share information to help women. Honored for the best research presentation at the Annual Meeting of the Society of Maternal-Fetal Medicine in 2008, he is currently co-principal investigator of the "Genomics and Proteomics Network" study and principal investigator of the study "Cooperative Agreement Application Multicenter Network of Maternal-Fetal Medicine Units." During his career, he has spearheaded several international studies, including a \$4-million venture to establish an electronic perinatal medical record system in Zambia, funded by the Bill and Melinda Gates Foundation. He also served as principal investigator on the \$3.5-million study entitled "Cooperative Agreement Application Multicenter Network of Maternal-Fetal Medicine."

In addition to his recent magnesium sulfate research, Dr. Rouse has investigated the use of progesterone in preventing preterm birth, perinatal and maternal outcomes in women with Sickle or Hemoglobin C traits, and the success rate of vaginal births after cesarean sections.

Dr. Rouse serves as editor-in-chief for obstetrics of *Obstetrical and Gynecological Survey*, and has served on the editorial board of *Obstetrics and Gynecology* and *Evidence-Based Obstetrics & Gynecology*.

## Moving Into the Future – Participate in the Process

The Office of Research on Women's Health is convening the third in a series of public hearings and scientific workshops to update the Women's Health Research Agenda at the National Institutes of Health for the coming decades. We are pleased that this meeting is co-hosted by the ORWH, along with The Warren Alpert Medical School of Brown University and Women & Infants Hospital.

"Moving Into the Future – New Dimensions and Strategies for Women's Health Research for the National Institutes of Health" will be held on September 21st through 23rd at Women & Infants. The ideas and recommendations emerging from this conference and other regional conferences will help inform future women's health research priorities at the NIH.

Focus areas for discussion at this workshop include:

- Prenatal, Infancy, and Childhood Years
- Adolescent Years

- Reproductive and Middle Years
- Pregnancy
- Menopausal Transition
- Elderly, Frail Elderly, and Healthy Aging
- Oral Health and Systemic Conditions
- Careers in Dentistry, Bioengineering, and Other Non-MD Disciplines

All of the sessions will be held at the Women & Infants Education Center in the new South Pavilion. This activity has been approved for AMA PRA Category 1 Credit.

## Women & Infants Now Offers Reproductive Infectious Diseases Consultation Service

**Brenna Anderson, MD, MSc**

*Attending Physician, Division of Maternal-Fetal Medicine, Women & Infants Hospital  
Assistant Professor, Department of Obstetrics and Gynecology, Alpert Medical School*

Have a tricky peripartum fever, complicated pelvic or lower genital tract infection, or post-operative pelvic infection, or have questions about the outpatient management of infectious disease associated with obstetrical or gynecological care?

Women & Infants is pleased to announce the initiation of a new Reproductive Infectious Diseases Consultation Service. This service will provide infectious disease expertise drawn from physicians with special training and competence in diagnosing and treating infectious complications in women. It will be directed by Dr. Brenna Anderson, who has completed fellowships in both maternal-fetal medicine and reproductive infectious diseases and is board certified. This service is a collaboration of the Department of Ob/Gyn, the Division of Infectious Diseases of the Department of Medicine at Brown University and the Department of Medicine at Brown/Women & Infants.

Dr. Anderson's team will work closely with referring doctors to provide services to inpatients as requested, ranging from a one-time consultation to ongoing co-management or assumption of infectious disease care. Outpatient consultations will also be provided for patients from the entire regional area.

For more information or to request a consult, please contact the Reproductive Infectious Diseases service at (401) 274-1122, extension 2358.



## MFMU Research Network Studies

### *TSH Study – A Randomized Trial of Thyroxine Therapy for Subclinical Hypothyroidism or Hypothyroxinemia Diagnosed During Pregnancy*

The TSH Study is a placebo-controlled interventional trial of thyroxine therapy in pregnant women with either subclinical hypothyroidism or hypothyroxinemia to determine if treatment of this group is effective in improving intellectual ability of the children. All pregnant women are eligible for screening, usually in their first prenatal visit. An additional tube of blood is drawn with prenatal labs and sent to a central lab for analysis. *Results consistent with subclinical hypothyroidism or hypothyroxemia quality for patient for the study.* Participants take levothyroxine or matching placebo daily from time of enrollment until delivery. Developmental testing is then done annually until age five, at which time IQ is determined.

The benefits of participation include free thyroid screening for your patients and developmental testing of the child, as well as the potential to standardize the threshold of treatment for thyroid conditions.

Study packets are provided to the offices of participating providers and are readily available at the time of routine blood sampling.

For more information, please contact Jo-Ann Hunt, RN, at (401) 274-1122, ext. 2853 or pager (401) 452-4677.

### *SCAN Study – A Randomized Trial of 17 Alpha-Hydroxyprogesterone Caproate for Prevention of Preterm Birth in Nulliparous Women with a Short Cervix*

The SCAN Trial is a placebo-controlled interventional trial being conducted to determine if progesterone therapy will decrease the risk of preterm birth in women with a short cervix. Nulliparous women with a singleton pregnancy at 16 to 22 weeks gestation are eligible for free cervical length screening. Women with a cervical length <30 mm are then offered enrollment and will receive weekly injections of progesterone/placebo through 36 weeks. Women may be referred for an initial cervical length screening or when a short cervix has been identified in your office. The study ultrasounds only measure cervical length and do not replace those done as part of routine clinical care.

For more information, please contact Donna Allard, RNC, at (401) 274-1122, ext. 2859 or pager (401) 452-4690.

## Physical Therapy for Pelvic Floor Disorders

### *Blair Washington, MD*

*Fellow, Division of Urogynecology and Reconstructive Pelvic Surgery, Women & Infants Hospital*

Pelvic floor disorders (PFDs) including urinary incontinence, fecal incontinence and pelvic organ prolapse are common and debilitating conditions. A recent study by the Pelvic Floor Disorders Network estimated the prevalence of at least one pelvic floor disorder to be 23.7%, with 15.7% of women experiencing urinary incontinence, 9% experiencing fecal incontinence, and 2.9% experiencing pelvic organ prolapse (Nygaard et al. 2008). Advancing age, increasing parity, and increasing body mass index are all factors which have been significantly associated with at least one PFD. As the United States population ages, the prevalence of these disorders will similarly increase.

The Agency for Health Care Policy and Research Clinical Practice Guidelines on urinary and fecal incontinence advocates a trial of nonsurgical therapy. Pelvic floor muscle training provides the foundation for the nonsurgical management of urinary incontinence.

The purpose of pelvic floor muscle training is to educate women to voluntarily contract the muscles of their pelvic floor. In the setting of stress urinary incontinence, pelvic floor muscle contraction increases intraurethral pressure thereby preventing urine loss during periods of increased abdominal pressure. With regard to urge incontinence, voluntary contraction of the pelvic floor results in a reflex inhibition of a detrusor contraction. Pelvic floor muscle training and biofeedback have been employed in the successful management of fecal incontinence. The objective is to increase the strength of the striated external anal sphincter, improve rectoanal coordination, and increase rectal sensory perception.

Although few studies have definitely demonstrated the benefit of pelvic floor physical therapy in the management of pelvic organ prolapse, the American College of Obstetricians and Gynecologists' Clinical Management Guidelines on prolapse recommends a trial of pelvic floor muscle training. Pelvic floor physical therapy should be

considered in the treatment of all patients with pelvic floor disorders as it is an effective, safe and non-invasive intervention.

Women & Infants offers a comprehensive array of services through the Program in Women's Physical Therapy. Outpatient services are offered through the Division of Urogynecology and Reconstructive Pelvic Surgery at 695 Eddy Street in Providence and also at the Care New England Center for Health, 49 South County Commons Way, South Kingstown. For information, call (401) 453-7560, ext. 108.

## The Tsunami of Genetics in Women's Health: What you need to know now!

### *Barbara O'Brien, MD*

*Attending Physician, Division of Maternal-Fetal Medicine, Women & Infants Hospital*

*Director, Perinatal Genetics, Women & Infants Hospital*

*Associate Director, Core Clerkship in Obstetrics and*

*Gynecology, Women & Infants Hospital*

*Assistant Professor, Department of Obstetrics and Gynecology, Alpert Medical School*

A CME course focusing on genetics over the lifespan is planned for Saturday, November 7<sup>th</sup>. The title says it all-- the field of genetics continues to expand at a very rapid pace, making it difficult for health care providers to keep up with the latest technology and innovation. This one-day course is aimed for a broad audience, including health care providers from family medicine, internal medicine, obstetrics and gynecology and its subspecialties, genetic counselors, pediatricians, neurologists, and anyone interested in keeping up-to-date with the latest in the field of genetics.

This course has something for everyone—from the early learner to the more advanced learner in genetics. Topics will be broad, (cont'd on page 4)

ranging from preconception through cancer and aging. World renowned speakers, such as our newly recruited Director of Maternal-Fetal Medicine Dr. Katharine Wenstrom, will speak on personalized medicine and direct to consumer marketing.

The morning will consist of many of Women & Infants' own extraordinary talent as well as other outstanding speakers enlightening us on subjects as varied as: preimplantation genetic diagnosis, first trimester screening, the latest cytogenetic techniques, cell free nucleic acids in maternal circulation, and common genetic disorders encountered in everyday obstetrics. The afternoon brings pediatric topics such as the genetics of autism, and the role of microarray in the prenatal and postnatal setting. Finally, the day will end with the genetics of cancer, including when to test for BRCA, and an update on ovarian cancer screening.

Please plan on joining us for a day that will prove to be exciting and filled with much learning!

### Dr. Robert Legare Named Medical Director of Women & Infants' Breast Health Center



Robert Legare, MD, was recently named medical director of the Breast Health Center, part of the Program in Women's Oncology at Women & Infants Hospital. Dr. Legare is a medical oncologist/hematologist and has served as acting medical director of the Breast Health

Center. In addition, he serves as medical director of the Cancer Risk Assessment and Prevention Program at the Program in Women's Oncology and is an associate professor of medicine and obstetrics-gynecology at the Alpert Medical School, where he has earned several Dean's Teaching Excellence Awards.

"Bob Legare embodies the spirit and mission of the Breast Health Center and Program in Women's Oncology," notes Skip Granai, MD, director of the Program. "He is tireless in his efforts to help his patients grapple with their diagnosis and treatment, and he pursues research projects that will help women in the future. He is a superior and dedicated physician. We are lucky to have him leading the Breast Health Center."

During his tenure at the Breast Health Center, Dr. Legare has launched the Cancer Risk Assessment and Prevention Program, a comprehensive service that taps the latest advances in the understanding of the genetic aspects of cancer and their relationship to environmental factors. The only service of its kind in the region, the Program provides a complete analysis of a woman's cancer risk based on medical, familial and lifestyle factors.

He has also been an integral part of developing two fellowships in the Program in Women's Oncology, including the nation's only fellowship that combines gynecologic oncology with breast care. The fellowship is approved by the Society of Surgical Oncology.

"He is in charge of a program that includes a fellowship that is a model for the entire nation," Dr. Granai notes, adding that the fellowship is under the direction of Jennifer Gass, MD, surgeon-in-chief at Women & Infants and associate director of the Breast Health Center. "The Program in Women's Oncology is unique in that it truly integrates all services for women. Dr. Legare is a faithful steward of this uncommon structure of care."

Dr. Legare earned a medical degree from Tufts University School of Medicine and completed a residency at Yale-New Haven Hospital and a research/clinical fellowship at Harvard Medical School and Brigham & Women's Hospital. At that time, he served as an associate physician at both Brigham & Women's and the Dana-Farber Cancer Institute and as an instructor in medicine at Harvard Medical School.

He is a member of the American Society of Clinical Oncology, American Society of Hematology, Brown University Oncology Group, and the author of many papers, abstracts and chapters.

### Fetal Treatment Program Announces New Leading-Edge Capability

The Fetal Treatment Program of Hasbro Children's Hospital, the pediatric division of Rhode Island Hospital, Women & Infants Hospital and The Warren Alpert Medical School of Brown University, is proud to announce the leading-edge capability of in utero intervention for severe congenital diaphragmatic hernia (CDH).

CDH historically has been associated with very high mortality rates. However, improvements in perinatal care in the last few decades have resulted in survival rates of more than 70 percent. Still, a subset of infants with CDH and extreme pulmonary hypoplasia does not survive despite maximal postnatal treatment. Fetuses with an isolated CDH, liver in the chest and a lung-to-head ratio of <0.9 have a predicted survival of less than 10 percent, based on several recent studies. For these patients, prenatal intervention may offer the possibility of catch-up lung growth by in utero occlusion of the trachea.

After more than a decade of research at this and other centers, single-port endoscopic placement of a detachable balloon can now be performed clinically. Our program is one of only two in the U.S. with FDA approval to treat pulmonary hypoplasia prenatally, with minimally invasive endoscopic tracheal occlusion. This modality is offered only for isolated CDH with intrathoracic liver and an LHR of <0.9. The fetal trachea is occluded around 26 to 29 weeks; the occlusion is released at 34 weeks.

The Fetal Treatment Program comprises multidisciplinary experts in the diagnosis of fetal anomalies and the management of the unborn child. We specialize in congenital diaphragmatic hernia, twin-to-twin transfusion syndrome, congenital lung lesions and abdominal wall defects, as well as many other congenital conditions. Our program provides us with the opportunity to pioneer groundbreaking techniques and to offer families more treatment options.

For more information, call (401) 228-0559, visit [www.fetal-treatment.org](http://www.fetal-treatment.org) or email one of the program's co-directors, Stephen Carr, MD at [scarr@wihri.org](mailto:scarr@wihri.org) or Francois Luks, MD, PhD at [francois\\_luks@brown.edu](mailto:francois_luks@brown.edu).

### This Is Why ...

Women & Infants is building the largest single-family-room NICU in the nation and the most sophisticated inpatient unit for high-risk mothers in our region. The hospital's new South Pavilion is scheduled to be open for patient care the third week of September.

Come join us for dedication events September 12th through 14th. Visit [www.womanandinfants.org](http://www.womanandinfants.org) for details.

# Nausea and Vomiting in Pregnancy

## What you need to know

### INFORMATION FOR PATIENTS – Nausea and Vomiting in Pregnancy

**Donna LaFontaine, MD**

*Medical Director, Emergency Department/Triage; Division Chief, Emergency Ob/Gyn, Women & Infants Hospital*

Nausea and vomiting are very common in pregnancy. This condition often starts in the first two months of pregnancy and is usually gone by the half-way point of the pregnancy. For a few women, the nausea and vomiting may continue until delivery. Often called “morning sickness,” nausea and vomiting can happen at any time of the day.

#### Are nausea and vomiting harmful to my baby?

No. Most cases of nausea and vomiting will have no effect on your baby’s health. A woman’s body has enough stored food to provide the baby with the nutrition he/she needs. If you are unable to hold down food for more than 12 hours, or if you start to lose weight, you need to let your health care provider know. Your health care provider may recommend that you receive some fluids intravenously (through an IV in your arm) so you do not become dehydrated.

Note that nausea and vomiting in pregnancy are not usually associated with stomach pain or fever. If you experience pain or fever, please call your health care provider.

#### What can I do to help with nausea and vomiting?

There is no way to prevent morning sickness. But there are many things that you can try which are safe and may help with the symptoms. If you try some of these suggestions and continue to experience nausea and vomiting, you should call your health care provider.

- After you wake up, lie in bed for 10 minutes before getting up. Sudden movements can cause nausea.
- Some women find it helpful to eat one or two saltine crackers before getting out of bed.
- Eat several small meals throughout the day. Five small meals cause less nausea than three big meals. You never want your stomach to be too full or too empty.
- If you do vomit, wait an hour before you try to eat again. This will give your stomach time to settle down. But try to eat before you get very hungry.
- Try a diet high in carbohydrates, like pasta, rice, mashed potatoes, crackers, and toast.
- Also include lean proteins, like chicken and turkey.
- **DO NOT** eat greasy or spicy foods or foods with strong smells.
- Drink fluids between meals. Popsicles count, and they are absorbed slowly, so they may work well.
- Some women find that their prenatal vitamins cause some nausea. One trick is to take your prenatal vitamin with a spoonful of applesauce. You may need to switch to children’s chewable vitamins tablets. Talk about this with your health care provider.
- Applying pressure to a nerve in the wrist has been shown to help with nausea. This hasn’t been proven scientifically, but it is not harmful, so it may be worth a try. Pressure bands can be found at any pharmacy.
- Ginger can also help with nausea. Besides ginger ale, you may want to take a ginger supplement – 250 milligrams to be taken four times a day. Although there have been no large studies about ginger, there are no known problems with taking it.

#### Are there any medications I can take to help with my nausea and vomiting?

**Vitamin B6 (pyridoxine)** is sold over-the-counter and can reduce nausea and vomiting in some women. The suggested dose, which is safe in pregnancy, is 25 milligrams every eight hours.

If vitamin B6 is not working, you may want to try adding **doxylamine succinate** (one brand name is Unisom). This is also sold over-the-counter as 25 milligram tablets – take ½ **tablet** every eight hours, along with the vitamin B6. Be aware that doxylamine succinate causes drowsiness.

*It is important to check with your health care provider or pharmacist if you are taking any other medications to be sure there are no interactions.*

#### Can nausea and vomiting be more serious than just “morning sickness”?

If nausea and vomiting continue despite treatment, and if you lose more than five percent of your body weight, you may be diagnosed with **hyperemesis gravidarum**. This is the most severe form of morning sickness. It needs more intensive treatment and sometimes even staying in the hospital to treat it.

# Náuseas y vómitos durante el embarazo

## Qué usted necesita para saber

### INFORMACIÓN PARA PACIENTES – Náuseas y vómitos durante el embarazo

**Dra. Doma LaFontaine**

Directora Médica, Departamento de Emergencias/Triaje Jefa de División, Ginecología y Obstetricia de Emergencia, Women & Infants Hospital

Las náuseas y los vómitos ocurren comúnmente durante el embarazo. Con frecuencia, esta condición empieza en los primeros dos meses del embarazo y, normalmente, desaparece para la mitad del período de embarazo. Para unas pocas mujeres, las náuseas y los vómitos pueden continuar hasta el parto. A menudo denominadas “náuseas matutinas del embarazo,” las náuseas y los vómitos pueden verificarse en cualquier momento del día.

#### ¿Son las náuseas y los vómitos perjudiciales para mi bebé?

No. La mayoría de los casos de náuseas y vómitos no tiene ningún efecto en la salud del bebé. El cuerpo de una mujer almacena los alimentos necesarios para brindarle al bebé la nutrición que necesita. Si usted no puede contener ningún alimento durante más de 12 horas o empieza a perder peso, comuníquese a su proveedor de cuidados médicos. Éste podrá recomendar que usted reciba fluidos por la vía intravenosa (a través de su brazo) para evitar que se deshidrate.

Tenga presente que las náuseas y los vómitos que se verifican durante el embarazo no se vinculan normalmente con un dolor de estómago o con fiebre. Si siente dolor o tiene fiebre, por favor llame a su proveedor de cuidados médicos.

#### ¿Qué puedo hacer para aliviar las náuseas y los vómitos?

No hay forma de prevenir las náuseas del embarazo. Sin embargo, usted puede probar varias cosas consideradas seguras y que pueden atenuar los síntomas. Si usted sigue algunas de estas sugerencias y continúa experimentando náuseas y vómitos, llame a su proveedor de cuidados médicos.

- Después de despertarse, permanezca en la cama durante 10 minutos antes de levantarse. Los movimientos súbitos pueden ocasionar náuseas.
- A algunas mujeres les resulta efectivo comer una o dos galletas saladas antes de levantarse de la cama.
- Ingiera varias comidas pequeñas durante el día. Cinco comidas pequeñas causan menos náuseas que tres comidas grandes. Es mejor que su estómago no esté ni demasiado lleno ni demasiado vacío.
- Si usted vomita, espere una hora antes de intentar comer de nuevo. Esto permitirá que su estómago se normalice. Sin embargo, trate de comer antes de que sienta mucha hambre.
- Lleve una dieta rica en carbohidratos que incluya pasta, arroz, puré de papas, galletas y pan tostado.
- También incluya alimentos ricos en proteínas sin grasas, como pollo y pavo.
- **NO** ingiera comidas grasas o picantes con olores fuertes.
- Ingiera líquidos entre comidas. Esto incluye las paletas, las cuales se absorben lentamente y, por ende, puede ayudarle.
- Algunas mujeres consideran que las vitaminas prenatales les causan náuseas. Como truco, tome su vitamina prenatal con una cucharada de puré de manzana. Es posible que, en su lugar, tenga que tomar tabletas de vitamina infantil masticables. Converse con su proveedor de cuidados médicos sobre esto.
- Se ha demostrado que la aplicación de presión a un nervio de la muñeca ayuda a atenuar las náuseas. Esto no ha sido comprobado de manera científica, pero no es dañino; de manera que vale la pena intentarlo. Puede encontrar las bandas de presión en cualquier farmacia.
- El jengibre también puede ser útil. Además del *ginger ale*, sería recomendable que tomara un suplemento de jengibre – 250 miligramos, cuatro veces al día. A pesar de que no se ha realizado ningún estudio de importancia sobre los efectos del jengibre, se desconoce la ocurrencia de algún problema a consecuencia de tomarlo.

#### ¿Puedo tomar algún medicamento para aliviar las náuseas y los vómitos?

La **Vitamina B6 (piridoxina)** se vende sin receta médica y puede atenuar las náuseas y los vómitos en algunas mujeres. La dosis sugerida, la cual es segura durante el embarazo, es de 25 miligramos cada ocho horas.

Si la vitamina B6 no resulta, agregue **succinato de doxilamina** (*Unisom* es una de las marcas disponibles). También se vende sin necesidad de receta médica en forma de tabletas de 25 miligramos – tómese ½ **tableta** cada ocho horas, junto con la vitamina B6. Tome en cuenta que el succinato de doxilamina causa somnolencia.

Es importante que consulte con su proveedor de cuidados médicos o farmacéuta si está tomando otros medicamentos para asegurarse de que no haya interacciones.

#### ¿Es posible que las náuseas y los vómitos impliquen una condición más grave que las “náuseas matutinas del embarazo”?

Si las náuseas y los vómitos continúan a pesar del tratamiento, y usted pierde más del cinco por ciento de su peso corporal, es posible que le diagnostiquen una **hiperemesis gravídica** (*hyperemesis gravidarum*). Esta es la forma más grave de las náuseas del embarazo. Requiere un tratamiento más intensivo y, en ocasiones, hasta una estadía en el hospital.