

Research Article

Incidence of depression and post natal depression in women with hyperemesis gravidarum and NVP

Sania Pirzada¹, Maria Azad²
and Uzma Zaman³

¹Sheikh Zed Women Hospital, Larkana.

²Federal Government Polyclinic

³DHQ Teaching Hospital, Dera Ismail Khan

Corresponding Author: Dr Sania Pirzada, Sheikh Zed Women Hospital, Larkana.

[Received: 25/01/2019; Accepted: 26/05/2019; Published: 30/05/2019]

ABSTRACT

Introduction: Pregnant women with severe nausea and vomiting may have hyperemesis gravidarum (HG), a separate entity from nausea and vomiting of pregnancy (NVP), which if left untreated may lead to increased maternal and fetal morbidity. **Aims and objectives:** The main objective of the study is to analyse the Incidence of depression and post natal depression in women with hyperemesis gravidarum and NVP. **Material and methods:** This cross sectional study was conducted in Sheikh Zed Women Hospital, Larkana during March 2018 to December 2018. This study was done with the permission of ethical committee of hospital. Data were collected from 100 pregnant female patients. Participants were selected through randomly sampling technique. All the data were collected through a questionnaire. The data was divided into two groups, one was control group and one was selected patients. We compare the selected patients with control group. **Results:** The data was collected from 100 female patients. The mean maternal age of study and control groups were 28.4 ± 5.5 and 29.4 ± 5.7 years, respectively. Median gestational age of study participants was 11.1 ± 2.1 weeks and 10.9 ± 2.2 weeks for controls. No statistically significant difference was observed between the study and control groups in terms of maternal and gestational age, gravidity, parity, abortus, occupation, housing, and education levels. Only nine women in the NVP group reported a history of cigarette smoking before pregnancy, which was statistically insignificant between groups. **Conclusion:** It is concluded that NVP and HG are two of the most common medical conditions of pregnancy, management can be very challenging for the clinician.

Key words: Gestational, pregnant, Hyperemesis

INTRODUCTION

Pregnant women with severe nausea and vomiting may have hyperemesis gravidarum (HG), a separate entity from nausea and vomiting of pregnancy (NVP), which if left untreated may lead to increased maternal and fetal morbidity. HG is infrequent when compared with NVP and occurs in 0.3%–2% of all pregnancies. The severity of complaints might vary from one pregnant woman to another and even between pregnancies of the same

woman, which suggest the contribution of genetic, biological, and psychological factors¹. In addition to the physical condition of pregnancy, NVP and HG also negatively affect the mental health, quality of life, and functional capacity of women. In severe cases, fetal development might also be affected². Although there are still questions regarding the exact cause of both conditions, it does appear to be associated with various metabolic and endocrine

factors³. In this context, the most implicated factor is suggested to be the production of the human chorionic gonadotropin hormone. Moreover, there is evidence that links this condition to alternation in a variety of hormones, including estrogen, progesterone, placental prostaglandin E₂, and thyroid-stimulating hormone⁴.

Nausea and vomiting in pregnancy (NVP) has for a long time fascinated the scientific community for two main reasons: its high prevalence, which has rendered it into one of the symptoms of early pregnancy and its great symptom variability, from early physiological nausea of pregnancy to a more severe condition, which may result even in maternal death at its worst form. NVP affects 50–90% of pregnant women⁵. Symptoms begin early in the first trimester, peak at around nine gestational weeks (GW) and typically cease at GW 20⁴. In 0.3–2.3% of cases it progresses to the more severe condition hyperemesis gravidarum (HG) and in 5–22% of affected women the symptoms persist throughout pregnancy⁶. WHO defines HG as NVP starting before 22 GW but the duration of symptoms and the time-point of symptom ceasing are not noted. The vast majority of published studies focus on HG, the most severe form of NVP requiring hospitalisation and/or parenteral nutrition⁷.

Theoretical background

NVP occurs in 50–90% of pregnancies, with nausea and vomiting in approximately 50–55% and nausea alone in 25%. Although NVP has been commonly referred to as “morning sickness,” nausea can occur at any time of the day, last for varying periods of time, and occur with or without episodes of vomiting.

The usual onset for NVP is between 4–9 weeks gestational age, with maximal symptoms at 12–15 weeks, and resolution by 20 weeks gestational age⁸.

AIMS AND OBJECTIVES

The main objective of the study is to analyse the Incidence of depression and post natal depression in women with hyperemesis gravidarum and NVP.

MATERIAL AND METHODS

This cross sectional study was conducted in Sheikh Zed Women Hospital, Larkana during March 2018 to December 2018. This study was done with the permission of ethical committee of hospital. Data were collected from 100 pregnant female patients. Participants were selected through randomly sampling technique.

Data collection

All the data were collected through a questionnaire. The data was divided into two groups, one was control group and one was selected patients. We compare the selected patients with control group. After inclusion, gestational age was determined according to the first day of last menstruation corrected by ultrasound finding when the discrepancy exceeded one week. A detailed sociodemographic data form was given to all subjects. Pregnancy characteristics, age, medication history, tobacco and alcohol use, and educational and familial status were recorded.

Statistical analysis

The data was collected and analysed using SPSS version 21.0. Student’s t-test was used to compare the data that was normally distributed. Data non-normally distributed were compared using the Mann–Whitney U test.

RESULTS

The data was collected from 100 female patients. The mean maternal age of study and control groups were 28.4±5.5 and 29.4±5.7 years, respectively. Median gestational age of study participants was 11.1±2.1 weeks and 10.9±2.2 weeks for controls.

No statistically significant difference was observed between the study and control groups in terms of maternal and gestational age, gravidity, parity, abortus, occupation, housing, and education levels.

Only nine women in the NVP group reported a history of cigarette smoking before pregnancy, which was statistically insignificant between groups.

Table 01: Socio-demographic characteristics of study participants

| | | NVP patients | Controls | p |
|-------------------------|----------------|--------------|-----------|--------|
| Age (years) | | 28.4±5.5 | 29.4±5.7 | NS |
| Gestational age (weeks) | | 11.1±2.1 | 10.9±2.2 | NS |
| BAI | | 13 (0–43) | 4 (0–26) | <0.001 |
| EPDS | | 7 (0–20) | 4 (0–16) | NS |
| Gravida | | 2 (1–7) | 2 (1–5) | NS |
| Education | | | | NS |
| | Illiterate (%) | 5 (6.0) | 4 (4.8) | |
| | Primary (%) | 22 (26.5) | 13 (15.6) | |
| | High (%) | 32 (38.5) | 36 (43.3) | |
| | University (%) | 24 (29.0) | 30 (36.3) | |
| Cigarette smoking | | | | NS |
| | No (%) | 74 (89.1) | 70 (84.3) | |
| | Yes (%) | 9 (10.9) | 13 (15.7) | |

If the diagnosis of NVP or HG is made, but there is poor response to initial interventions, an atypical presentation, or initial presentation after 9–10 weeks, other causes must be explored. Table 02 lists other potential causes of nausea and vomiting in pregnancy. If there is fever, a source of infection should be sought or if the history suggests a CNS abnormality, check for signs of raised intracranial pressure.

Table 02: Differential diagnosis of NVP

| | |
|---------------------|---------------------------------|
| Peptic ulcer | Urinary tract infection |
| Hepatitis | CNS abnormality |
| Pyelonephritis | Preeclampsia |
| Pancreatitis | Acute fatty liver of pregnancy |
| Cholecystitis | Gastroesophageal reflux disease |
| Appendicitis | Mallory-Weiss tear |
| Gastroenteritis | Hyperthyroidism |
| H. pylori infection | |

DISCUSSION

Prolonged nausea and vomiting in the setting of NVP or HG can lead to maternal vitamin deficiencies. As mentioned above, Wernicke’s encephalopathy is a potential serious or fatal maternal complication and is due to severe vitamin B1 (thiamine) deficiency. Approximately 47% of patients with this condition will present with a history of prolonged nausea and vomiting along with the triad of abnormal ocular movements, ataxia, and confusion; an additional percentage will also have diplopia⁹. Symptoms can also be more variable and include memory loss, apathy,

decreased level of consciousness, or blurred vision. Although this condition is reversible with prompt treatment, 60% of women will have residual impairment and there is a 37% fetal loss rate¹⁰. Because maternal serum thiamine levels are not useful in making the diagnosis, any pregnant woman who presents with prolonged nausea and vomiting and neurologic abnormalities should be empirically treated with intravenous thiamine¹¹. Deficiencies in vitamins B6 and B12 are rare and not as potentially serious, but can cause anemia and peripheral neuropathy associated with hematemesis, malnutrition, and psychological effects. Vitamin

K deficiency and coagulopathy can also occur, leading to an abnormal coagulation profile and bleeding¹².

One consequence of NVP and HG that is commonly neglected, especially when the focus is on treatment, is the psychosocial impact of this disorder. NVP can adversely affect family and social life, physical and mental health, employment, and can impose an economic hardship¹³. This can range from missing days of work to termination of the pregnancy due to severe symptoms. Up to 25% of pregnant women have to change their normal daily activities due to symptoms. In addition, these women have lower physical and social functioning and miss more days of work¹⁴.

CONCLUSION

It is concluded that NVP and HG are two of the most common medical conditions of pregnancy; management can be very challenging for the clinician. Women with prolonged NVP beyond GW 17 have higher odds for self-reported depressive symptoms at six weeks postpartum, a finding observed even among women without previous depression.

REFERENCES

1. Bozzo P, Einarson TR, Koren G, Einarson A. Nausea and vomiting of pregnancy (NVP) and depression: cause or effect? *Clinical and investigative medicine. Medecinecliniquetexperimentale*. 2011;34: E245.
2. Kramer J, Bowen A, Stewart N, Muhajarine N. Nausea and vomiting of pregnancy: prevalence, severity and relation to psychosocial health. *MCN. The American journal of maternal child nursing*. 2013;38:21–27.
3. Mitchell-Jones N, et al. Psychological morbidity associated with hyperemesis gravidarum: a systematic review and meta-analysis. *BJOG: an international journal of obstetrics and gynaecology*. 2017;124:20–30.
4. Aksoy H, et al. Depression levels in patients with hyperemesis gravidarum: a prospective case-control study. *SpringerPlus*. 2015;4:34.
5. Axfors C, Sylven S, Ramklint M, Skalkidou A. Adult attachment's unique contribution in the prediction of postpartum depressive symptoms, beyond personality traits. *Journal of affective disorders*. 2017;222:177–184.
6. Iliadis SI, et al. Prenatal and Postpartum Evening Salivary Cortisol Levels in Association with Peripartum Depressive Symptoms. *PloS one*. 2015;10:e0135471.
7. Iliadis SI, et al. Associations between a polymorphism in the hydroxysteroid (11-beta) dehydrogenase 1 gene, neuroticism and postpartum depression. *Journal of affective disorders*. 2017;207:141–147.
8. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *The British journal of psychiatry: the journal of mental science*. 1987;150:782–786.
9. Rubertsson C, Borjesson K, Berglund A, Josefsson A, Sydsjo G. The Swedish validation of Edinburgh Postnatal Depression Scale (EPDS) during pregnancy. *Nordic journal of psychiatry*. 2011;65:414–418.
10. Wickberg B, Hwang CP. The Edinburgh Postnatal Depression Scale: validation on a Swedish community sample. *ActapsychiatricaScandinavica*. 1996;94:181–184.
11. Fiaschi L, Nelson-Piercy C, Tata LJ. Hospital admission for hyperemesis gravidarum: a nationwide study of occurrence, reoccurrence and risk factors among 8.2 million pregnancies. *Human reproduction (Oxford, England)* 2016;31:1675–1684.
12. London V, Grube S, Sherer DM, Abulafia O. Hyperemesis Gravidarum: A Review of Recent Literature. *Pharmacology*. 2017;100:161–171.
13. Fejzo MS. Measures of depression and anxiety in women with hyperemesis

gravidarum are flawed. Evidence-based nursing. 2017;20:78–79.

14. King TL, Murphy PA. Evidence-based approaches to managing nausea and vomiting in early pregnancy. Journal of midwifery & women's health. 2009;54:430–444.