# Managing Tummy Troubles During Pregnancy

Growing a baby is hard work, and it often comes with a side of extra hunger as your body fuels the little one inside. While the idea of "eating for two" is a common myth, changes in hunger levels, digestion, and food tolerance are very real. For example, you might sit down to enjoy a meal you've eaten countless times before, only to experience sudden heartburn that just won't quit. Or you may plan a short outing and unexpectedly find yourself searching for the nearest restroom due to an upset stomach. These common experiences can be both frustrating and surprising. Symptoms such as heartburn, indigestion, upset stomach, and diarrhea can disrupt daily routines, interfere with sleep, and make even simple moments feel uncomfortable during pregnancy.

Comfort plays a vital role in promoting both physical and emotional health. This includes maintaining balanced nutrition, staying hydrated, being physically active (safely) and trying to get enough quality rest. Comfort is not a luxury; it is an important part of staying healthy for both you and your baby. However, it's important to remember to check your usual remedies to make sure they can also be used during pregnancy.

Bismuth subsalicylate is an over-the-counter medicine often used to treat symptoms such as nausea, heartburn, indigestion, upset stomach, and diarrhea. Once bismuth subsalicylate reaches your stomach and intestines, it separates into salicylic acid (which the body can absorb) and bismuth compounds that are mostly not absorbed. Bismuth subsalicylate is related to aspirin, as they are both in a group of mediations called salicylates. Products that include this ingredient are Pepto-Bismol®, Bismatrol®, Diotame®, Kaopectate®, and Kao-Tin®.

## *Can Products Containing Bismuth Subsalicylate Be Used During Pregnancy?*

In general, products that contain bismuth subsalicylate are not recommended for use during pregnancy, especially during the second and third trimesters. Here is why:

- Bismuth subsalicylate is related to aspirin, which is a non-steroidal anti-inflammatory (NSAID) medication. NSAIDs can increase the chance of certain risks in pregnancy, such as bleeding complications.
- There are concerns about the effects on the fetal kidneys and lower levels of amniotic fluid (the fluid that surrounds the fetus during pregnancy).
- There are concerns about effects on the fetal heart and blood vessels if taken in the later stages of pregnancy. This can cause high blood pressure in the fetal lungs (pulmonary hypertension).

Luckily, there are other ways to help manage those annoying tummy troubles. ***Note: Be sure to use medications and other treatments as directed on the label or by your healthcare provider.***

- For heartburn and indigestion: Antacids like calcium carbonate (Tums®) can be used as directed in pregnancy. Using them may also help with your calcium intake.

- For nausea: Vitamin B6 supplements, doxylamine (an antihistamine), or ginger have been recommended by healthcare providers. Your provider may also suggest prescription medications if needed.

- For diarrhea: It is important to stay hydrated. Your provider may recommend medication depending on the cause and severity of your condition.

- MotherToBaby has fact sheets on these exposures:
  - Regular Strength Aspirin
  - Calcium carbonate
  - Doxylamine succinate-pyridoxine hydrochloride
  - Ginger

Always check with your healthcare provider before taking any medication during pregnancy, even if it is over the counter. They can talk with you about your symptoms and what treatment is best for you.

## What If I Already Took Pepto-Bismol?

First, do not panic. One dose is unlikely to cause harm. But it is still a good idea to mention it to your healthcare provider, especially if you are in your second or third trimester. They can help assess whether any follow-up is needed and reassure you moving forward. They can also talk with you about the best way to treat your symptoms during pregnancy.

Pregnancy can already feel uncomfortable at times, so dealing with stomach issues on top of everything else can be frustrating. While some common ingredients like bismuth subsalicylate aren't recommended during pregnancy, there are options that can help you feel better. When in doubt, it's okay to ask your healthcare provider or a MotherToBaby specialist. Remember, taking care of your comfort is an important part of taking care of your pregnancy.

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Thinking about pregnancy while also worrying about weight can feel stressful. You are not alone—about 6 in 10 women in the U.S. are overweight or have obesity. Talking about weight can be hard, but it is an important part of planning for a healthy pregnancy.

This blog will explain how weight can affect pregnancy, what GLP-1 medications are, and what we know so far about their use before and during pregnancy.

### *Why Is Managing Weight Before Pregnancy So Important?*

Being overweight or having obesity increases the chance for several pregnancy-related problems, including:

- Miscarriage
- Birth defects
- Preterm delivery (before 37 weeks)
- Gestational diabetes
- High blood pressure during pregnancy
- Stillbirth
- Cesarean delivery
- Thromboembolic events (blood clots)

You can read more about obesity and pregnancy in our factsheet here:
https://mothertobaby.org/fact-sheets/obesity-pregnancy/

The good news is even a small weight loss—just 5–7% of your body weight—before pregnancy can improve health and pregnancy outcomes. Starting before you get pregnant is best. Some people do this through healthy eating and exercise, while others may need surgery or medication.

## What Are GLP-1 Medications?

GLP-1s are medicines that act like a natural hormone in your body. They help control blood sugar, slow down digestion, and make you feel full longer. This can lead to weight loss. Most GLP-1s are given as shots. The best-known ones are liraglutide (Victoza®) and semaglutide (Ozempic®, Wegovy®, Rybelsus®). These are also the ones most studied in pregnancy so far.

## Can I Use GLP-1s While Trying to Get Pregnant?

The current product labels recommend stopping GLP-1 medications at least 2 months before pregnancy. The time it takes the body to process medication is not the same for everyone. In healthy non-pregnant women, it can take up to 6 weeks, on average, for most of the GLP-1s to be gone from the body.

Stopping the medicine can sometimes cause weight gain, which can feel frustrating. Because of this, some people choose to continue until they know they are pregnant. It's best to talk with your healthcare provider about the risks and benefits for you.

## What Do We Know About GLP-1s in Pregnancy?

Here's what research tells us so far:

- Studies including over 1,000 women exposed to GLP-1s during the first trimester have not shown an increased chance of birth defects.
- A study of 168 pregnancies with first-trimester exposure to GLP-1s did not show increased chance of miscarriage, preterm delivery, stillbirth, or SGA infants (small for gestational age-infants whose birth weight is below the $10^{th}$ percentile for their gestation age).

It's important to remember that every pregnancy has a baseline risk:

- Out of all babies born each year, about 3 out of 100 (3%) will have a birth defect
- 15 to 20 out of every 100 (15-20%) pregnancies end in miscarriage

These typically occur in the first trimester — whether or not medication is used.

## Why Are GLP-1s Not Recommended During Pregnancy?

At this time, continuing GLP-1s after pregnancy is confirmed is not recommended for two main reasons:

- Weight loss during pregnancy is not advised. Losing weight while pregnant may increase the chances of having a baby with SGA, which can lead to complications such as:
  - Low oxygen levels
  - Low Apgar scores (grading system in newborns to define their wellbeing)
  - Meconium aspiration (breathing in the first bowel movement)
  - Hypoglycemia (low blood sugar)
  - Difficulty maintaining body temperature
  - Polycythemia (too many red blood cells)
- We lack research on GLP-1s in the second and third trimesters. Without research studies on the use in the second and third trimester, we don’t know if use of GLP-1s could increase the chances of other pregnancy-related problems.

## Finding the Path That's Right for You

Your journey is unique, and there's no simple answer. That's why it's so important to talk with your healthcare provider about the best way to approach weight management before pregnancy.  As Dr. Sarah Obican so masterfully said in a previous Baby Blog post:

"Each of us are beautifully individual" — and our weight loss and pregnancy journeys are beautifully individual, too.

## Final Thoughts

Whether you're already on a weight loss journey or just starting to think about pregnancy, you deserve support and trusted information. We're here to help you every step of the way.

## 🔗 Helpful Links:

**Factsheets:**

- Obesity and Pregnancy:https://mothertobaby.org/fact-sheets/obesity-pregnancy/
- Semaglutide: https://mothertobaby.org/fact-sheets/semaglutide/

**Baby Blogs:**

- Battling Obesity Ahead of Pregnancy is 'Beautifully Individual':https://mothertobaby.org/baby-blog/battling-obesity-ahead-of-pregnancy-is-beautifully-individual/

**Podcasts:**

- Ep. 84: GLP-1 Medications & Pregnancy: What We Know So Far: https://mothertobaby.org/podcast/ep-84-glp-1-medications-pregnancy-what-we-know-so-far/
- Ep. 64: Weight Loss and Ozempic in Pregnancy: https://mothertobaby.org/podcast/ep-64-weight-loss-and-ozempic-in-pregnancy/

Have questions about a specific medication or concern? Reach out to our MotherToBaby experts by phone, text, email or live chat at MotherToBaby.org.

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Marie called with a question, “My baby is 4 weeks old, and my husband and I love her to death. However, she is a lot of work, and we do not want another little one quite yet. My husband and I are also hoping to resume our sex life, but can I be on birth control while breastfeeding?”

MotherToBaby is here to help answer some of those questions!  Of course, before you decide, it is best to speak with your medical provider and get their advice.  Since everyone is different, some birth control methods might not be a good match for you.

### *Can breastfeeding be used as contraception?*

There are many benefits to breastfeeding. Breastmilk has antibodies that are passed to the baby and help them build their immune system and protect against illnesses. Breastmilk is also a great source of nutrition. When a woman is breastfeeding, they might experience amenorrhea (when you do not have a monthly a menstrual period). Breastfeeding can be a temporary form of birth control if the person is exclusively breastfeeding (i.e., no formula), they have not had a menstrual period yet, and the baby is less than 6 months old. This method is sometimes called the “lactational amenorrhea method (LAM)”. LAM does not work for everybody and may not be reliable enough for all couples. Some people do not develop amenorrhea when breastfeeding, so another form of birth control would be recommended.

## Are there other forms of birth control that I can use when breastfeeding?

Many contraceptive methods do not affect your breastfeeding. However, options which contain estrogen might reduce your milk supply. Depending on what option you choose, your healthcare team may suggest that you wait up to 4-6 weeks after delivery so that your milk supply is well established, and your body has recovered from childbirth.

Another factor is how serious you are about preventing another pregnancy. Some options such as the IUD, hormonal implant, and Depo-Provera injection are 98-99% effective in preventing pregnancy (this means only 1 or 2 out of 100 women will get pregnant every year using those methods). The birth control pill is around 93% effective in preventing pregnancy (this means around 7 out of 100 women will get pregnant every year using birth control pills). The condom is around 85% effective, depending on how carefully it is used (this means around 15 out of 100 women will get pregnant every year using this method).

The American College of Obstetricians and Gynecologists (ACOG) has a web page that answers frequently asked questions about contraceptives including advantages and disadvantages of each type: https://www.acog.org/womens-health/faqs/postpartum-birth-control

## Hormonal Birth Control Options

There are many kinds of hormonal birth control options including pills taken orally (by mouth), injections, implants, and some IUDs. Some options contain forms of both estrogen and progesterone, and some just contain progesterone. In general, it is expected that only small amounts of the hormones would pass into your breastmilk, and these low levels are unlikely to result in any side effects in your baby. However, some of them can affect your milk supply.

Some estrogen-containing options include “combination birth control pills,” the skin patch, and the vaginal ring. A disadvantage of estrogen is that it can reduce or even stop milk supply. Healthcare providers usually recommend waiting to start estrogen-methods until at least 4 weeks after delivery to allow your milk supply to be well established.

Progesterone-only options include the progestin only pills (“mini pills”), the injection (ex. DepoProvera shot), the implant (ex. Nexplanon), the hormonal intrauterine device (IUD), and emergency contraception. Progesterone only options generally do not reduce your milk supply or affect milk quality. Some professional groups suggest waiting 4-6 weeks after giving birth before getting the Depo-Provera shot because the amount of hormone in your blood and milk

from this injection are highest around the time it is given.

## Non-Hormonal Birth Control Options

Non-hormonal birth control options include barrier methods like male and female condoms, spermicide, diaphragms, the cervical cap, the sponge, and the copper IUD.  None of these strategies impact milk supply.

## Fertility Awareness Methods/Lifestyle Options

Other birth control options that do not include hormones or barrier items are the calendar tracking option and abstinence. The calendar tracking option is when you track your menstrual cycle and avoid intercourse on the days you are most fertile (most likely to get pregnant). This method is not very reliable following childbirth because a menstrual cycle can be irregular during the first few months. Abstinence is the avoidance of vaginal intercourse and choosing to be intimate in other ways that cannot result in a pregnancy. Abstinence is 100% effective at preventing pregnancy.

## Summary

In summary, what is the best birth control option during breastfeeding? Each person will be different, so it is important to talk with your healthcare provider about which option is best for you based on the timing, effectiveness, family planning decisions, and your other personal health factors.

## Resources

2023. Postpartum Birth Control; Frequently Asked Questions. American College of Obstetrics and Gynecology. https://www.acog.org/womens-health/faqs/postpartum-birth-control

Berens P, Labbok M; Academy of Breastfeeding Medicine. ABM Clinical Protocol #13: Contraception During Breastfeeding, Revised 2015. Breastfeed Med. 2015 Jan-Feb;10(1):3-12. doi: 10.1089/bfm.2015.9999. PMID: 25551519.

2024. Contraception and Birth Control Methods. Centers for Disease Control and Prevention. https://www.cdc.gov/contraception/about/index.html

2024. About Breastfeeding. Centers for Disease Control and Prevention. https://www.cdc.gov/breastfeeding/php/about/index.html

Goulding Alison N., Wouk Kathryn, and Stuebe Alison M., Contraception and Breastfeeding at 4 Months Postpartum Among Women Intending to Breastfeed. Breastfeeding Medicine. January 2018, 13(1): 75-80.

Stanton TA, Blumenthal PD. Postpartum hormonal contraception in breastfeeding women. Curr Opin Obstet Gynecol. 2019 Dec;31(6):441-446. doi: 10.1097/GCO.0000000000000571. PMID: 31436540.

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# Managing Tummy Troubles During Pregnancy

***By Lynn Martinez and Julia Robertson, CPM***

During the more than 40 years MotherToBaby affiliates have been serving the public with education regarding exposures during pregnancy, many women have called who are very distressed, sometimes in tears, about finding out they were pregnant while taking a drug categorized as an X or D in the Food and Drug Administration (FDA) system. “I’ve been on birth control pills and I still got pregnant! Does this mean my baby will have birth defects? It’s a category X drug for goodness sake!” This kind of hysterical reaction was, unfortunately, a common call. It was not unusual to even hear that some of these women had contemplated terminations of otherwise wanted pregnancies. The FDA realized that these pregnancy categories were not as helpful as they intended and stopped using them in 2014, about ten years ago. Now they use the Pregnancy and Lactation Labeling Rule (PLLR) that has a narrative summary for medications, similar to what you will find here at MotherToBaby.

## *But first, a little background…*

For decades the FDA had been aware of significant problems with the system used to categorize medications for use in pregnancy. In 1992, the Teratology Society (now known as the Society for Birth Defects Research and Prevention), a group of multidisciplinary scientists who study birth defects, expressed concerns and noted that the Category or ‘CAT’ system led to unnecessary terminations of wanted pregnancies1. The FDA Pregnancy Labeling Initiative recommended elimination of the CAT system, changing the label to include more descriptive risk statements and mandating that drug inserts be updated when human information is known.

Before the labeling rule changed, when a medication was approved for marketing in the U.S., it had to be labeled with one of five pregnancy CATs: A, B, C, D or X. A meant the drug was well-studied and posed no threat to a developing baby; B was a less-studied, but probably still low-risk drug; C was a drug that had not been studied and therefore the risk was unknown; a D-class drug, based on animal or human data, may have posed a risk; and the X classification

meant the drug, based on animal or human data, causes birth defects or there was no benefit for its use during pregnancy. Its use was not recommended in pregnancy.

More than 90 percent of new medications were categorized as either CAT C, D or X, the vast majority being C. Drug manufacturers were legally required to update the category if harmful results were reported; however, no such requirement existed for updating the category when studies showed no problems in pregnancy. Most medications on the market in 2014 werelisted as CAT C, when in fact the majority of them should have been labeled as a CAT A or B. Manufacturers knew that no matter a woman's history, all pregnancies carried a 3 percent risk of having a child with a major birth defect. Because of this, many manufacturers may have felt better protected from lawsuits if their drugs were listed as CAT C, D, or X. So, really, why would they move up medications in those categories up to A or B? They really didn't have an incentive.

## Moving forward and what it means to mom…

With the FDA rule change in 2014, a new set of requirements was put into place to better inform mom. It now requires the manufacturers to 'upgrade' a medication's labeling when studies show the risk has changed. Also, manufacturers will have to explore various ways of discussing in detail the risks associated with the drug. One expert source that manufacturers could consult is a teratogen information service, like MotherToBaby. More information will help you make more informed choices about your health and pregnancy!

## There will still be confusion…

As we see the new labels being implemented, there will still be many drugs on the market with the CAT system since it'll take time to update all of them. MotherToBaby does not recommend the public or providers rely on the old CAT system for risk assessment. We welcome your questions about the system as well as questions about specific medications in pregnancy and breastfeeding for a complete, personalized risk assessment. Please call us toll-FREE at 866-626-6847.

Lynn Martinez is a retired Teratogen Information Specialist. Lynn has traveled around Utah educating doctors, nurse midwives, pharmacists and others over the past three decades.

Julia Robertson, CPM, now retired, works part-time overseeing quality control efforts for MotherToBaby. In her 25-year career as a teratogen information specialist, sheauthored several peer-reviewed publications focusing on maternal medication consumption and the effect on the developing fetus.

MotherToBaby is a service of the international Organization of Teratology Information Specialists (OTIS), a suggested resource by many agencies, including the Centers for Disease Control and Prevention (CDC). If you have questions about medications, alcohol, diseases, vaccines, or other exposures during pregnancy or breastfeeding, call MotherToBaby toll-FREE at 866-626-6847 or browse a library of **fact sheets**.


- Friedman, J. Teratology 1993:48:506
- For more information go to: **http://www.fda.gov/drugs/developmentapprovalprocess/developmentresources/labeling/ucm093307.htm**

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Baby it's cold outside…and 'tis the season for MotherToBaby to answer questions about cough and cold medications while breastfeeding.

### *Some "Cold" Hard Facts*

Factors such as your baby's age and whether they were born prematurely or have chronic health problems matter. Very young babies (less than 3 months old) may have a more difficult time metabolizing medications in the milk and may be more susceptible to side effects like sleepiness. Milk is also their complete diet, and some medications can reduce your milk supply. The older your baby is, the less likely it is that the medication will cause a serious problem in your baby, but it is still a good idea to be careful. We also consider how much of the medication typically ends up in breastmilk, and whether the medication is considered acceptable to give directly to a baby.

Many cough and cold medications come in combination products. In some cases, you end up taking extra medications for a symptom you do not have! Also, some medications act together to make more problems. For example, decongestants and antihistamines taken together may have extra ability to reduce milk supply. Taking a single medication at a time lets you be sure you are using only the one that you need.

Consider whether your symptoms need medical treatment…is it worth the potential exposure to your baby, especially since many medications have not been studied very well in breastfeeding? Non-medication strategies like a humidifier, warm shower or bath, or nasal irrigation with saline may be comforting.

Most vitamins or minerals taken over the recommended daily allowance (RDA) have not been studied very well in breastfeeding. Herbal agents are also poorly studied, which makes it difficult to tell if they are hazardous or not in breastfeeding. In general, supplements like this should be avoided.

## Fever and Body Aches

Common medications to treat these symptoms are acetaminophen and ibuprofen. Both end up in breastmilk in only small amounts and can be given directly to babies. When used as recommended on the label these medications are unlikely to harm your baby.

Aspirin is not given to babies because it may cause bleeding or a condition called Reye syndrome (swelling of the brain). Very little aspirin gets into breastmilk, but to be on the safe side you may want to be cautious about taking it when you are breastfeeding unless it is prescribed for a medical condition and your baby's health provider agrees with use.

## The Sniffles (medications that dry up your nose like decongestants and antihistamines)

Over-the-counter nasal decongestants fall into two categories: oral and topical/spray.

Oral (pill) decongestants include pseudoephedrine and phenylephrine. These medications are not given directly to babies and can make them jittery and sleep poorly, and may also reduce your milk supply.

Oral (pill) antihistamines include chlorpheniramine, doxylamine, and diphenhydramine. Varying amounts get into milk; they can make your baby sleepy or irritable, and may reduce your milk supply. They are also not medications given directly to babies.

Topical (spray) decongestants such as oxymetazoline have not been studied very well in breastfeeding. However, they are not very well absorbed from your nose, and thus not much is likely to get into your milk.

## Cough

The most common over the counter cough medications are dextromethorphan (cough suppressant) and guaifenesin (loosens up mucous). Not much dextromethorphan gets into milk; it is not known if guaifenesin gets into your milk. Some cough syrups contain alcohol, which would be a hazard for your baby. Be sure to check your label.

Cough lozenges may just have sugar and flavoring, or may include honey, menthol, zinc, or herbal agents. Read your label before you take the medicinal ones since many components have not been studied very well in breastfeeding.

We hope you feel better soon, and if you have further questions or notice side effects in your baby that you suspect may be related to a medication you are taking, speak with your baby's healthcare provider.

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