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LACTATION

Lactation, secretion and yielding of milk by females after giving birth. The milk is produced by the mammary glands, which are contained within the breasts.

The breasts, unlike most of the other organs, continue to increase in size after childbirth. Although mammary growth begins during pregnancy under the influence of ovarian and placental hormones, and some milk is formed, copious milk secretion sets in only after delivery. Since lactation ensues after a premature birth, it would appear that milk production is held back during pregnancy. The mechanism by which this inhibitory effect is brought about, or by which lactation is initiated at delivery, has long been the subject of an argument that revolves around the opposing actions of estrogen, progesterone, and prolactin, as studied in laboratory animals, goats, and cattle. During pregnancy the combination of estrogen and progesterone circulating in the blood appears to inhibit milk secretion by blocking the release of prolactin from the pituitary gland and by making the mammary gland cells unresponsive to this pituitary hormone. The blockade is removed at the end of pregnancy by the expulsion of the placenta and the loss of its supply of hormones, as well as by the decline in hormone production by the ovaries, while sufficient estrogen remains in circulation to promote the secretion of prolactin by the pituitary gland and so favour lactation.

For lactation to continue, necessary patterns of hormone secretion must be maintained; disturbances of the equilibrium by the experimental removal of the pituitary gland in animals or by comparable diseased conditions in humans quickly arrest milk production. Several pituitary hormones seem to be involved in the formation of milk, so that it is customary to speak of a lactogenic (“milk-producing”) complex of hormones. To some degree, the role of the pituitary hormones adrenocorticotropin, thyrotropin, and growth hormone in supporting lactation in women is inferred from the results of studies done on animals and from clinical observations that are in agreement with the results of animal studies. Adrenal corticoids also appear to play an essential role in maintaining lactation.

The stimulus of nursing or suckling supports continued lactation. It acts in two ways: it promotes the secretion of prolactin (and possibly other pituitary hormones of value in milk formation), and it triggers the release of yet another hormone from the pituitary gland—oxytocin, which causes the contraction of special muscle cells around the alveoli in the breast and ensures the expulsion of milk. It is in this way that a baby’s sucking at one breast may cause an increase in milk flow from both, so that milk may drip from the unsuckled nipple. About 30 seconds elapse between the beginning of active suckling and the initiation of milk flow.

The nerve supply to the mammary glands is not of great significance in lactation, for milk production is normal after the experimental severing of nerves to the normal mammary glands in animals or in an udder transplanted to the neck of a goat. Milk ejection, or “the draught,” in women is readily conditioned and can be precipitated by the preparations for nursing. Conversely, embarrassment or fright can inhibit milk ejection by interfering with the release of oxytocin; alcohol, also, is known to block milk ejection in women, again by an action on the brain. Beyond its action on the mammary glands, oxytocin affects uterine muscle, so that suckling can cause contractions of the uterus and may sometimes result in cramp. Since oxytocin release occurs during sexual intercourse, milk ejection in lactating women has been observed on such occasions. Disturbance of oxytocin secretion, or of the milk-ejection reflex, stops lactation just as readily as a lack of the hormones necessary for milk production, for the milk in the breast is then not extractable by the infant. Many instances of nursing failure are due to a lack of milk ejection in stressful circumstances; fortunately, treatment with oxytocin, coupled with the reassurance gained from a successful nursing, is ordinarily successful in overcoming the difficulty.

Suckling can initiate lactation in nonpregnant women. This has been seen most often in women of childbearing age but also has been observed in older persons. A baby who had lost his mother was suckled by his 60-year-old grandmother, who had borne her last child 18 years before. The grandmother produced milk after a few days and continued to nurse the baby until he was a year old and could walk. Rarely, lactation has been reported to set in after operations on the chest; in such instances it is attributed to injury or irritation of the nerves in this region. Such observations argue against the possibility that lactation continues simply as a consequence of emptying the breasts.

The milk released from the breast when lactation starts differs in composition from the mature milk produced when lactation is well established. The early milk, or colostrum, is rich in essential amino acids, the protein building blocks essential for growth; it also contains the proteins that convey immunity to some infections from mother to young, although not in such quantity as among domestic animals. The human infant gains this type of immunity largely within the uterus by the transfer of these antibody proteins through the placenta; the young baby seldom falls victim to mumps, measles, diphtheria, or scarlet fever. For a short time after birth, proteins can be absorbed from the intestine without digestion, so that the acquisition of further immunity is facilitated. The growth of harmful viruses and bacteria in the intestines is probably inhibited by immune factors in human milk. After childbirth the composition of milk gradually changes; within four or five days the colostrum has become transitional milk, and mature milk is secreted some 14 days after delivery.

Some variations between human colostrum, transitional milk, and mature milk and cow’s milk are shown in Table 2. The greater amount of protein in unmodified cow’s milk is largely responsible for its dense, hard curd, which the infant cannot digest; the difficulty can be avoided by heat treatment or dilution of the milk. Ordinarily, when cow’s milk is fed to young infants, it is modified so as to match its composition as far as possible to breast milk.

PREGNANCY

Pregnancy is the time from fertilization of an egg, also known as conception, to birth. Getting pregnant and growing a human from scratch is a very complicated biological process that takes a lot of resources. As a result, pregnancy can have a wide range of effects on the mother, both physically and emotionally.

Each egg that is released during a menstrual cycle travels to your uterus. However, unlike unfertilized eggs that proceed unaltered and then disintegrate when they get there, a fertilized egg develops into a tiny human embryo on the way. On reaching the uterus, the embryo implants itself in the uterine wall, develops into a fetus, and steadily grows, until about nine months later it is ready to emerge into the outside world as a newborn baby.

Illustration of fertilization

Illustration of fertilization

Signs and symptoms

If you are fertile, sexually active, and become pregnant, the first thing you are likely to notice is a late or missing menstrual period. Fertilization of an egg triggers changes in the production of various hormones almost immediately, and hormone changes evolve and persist throughout your pregnancy to help you grow a healthy baby. Unfortunately, these changes may also cause unpleasant side effects. As a result, in addition to a missed period, many women experience tender, swollen breasts, fatigue, nausea and vomiting, or morning sickness during the first few weeks of becoming pregnant.

Diagnosis

If you are experiencing some or all of the early signs and symptoms of pregnancy, or if you suspect you might be pregnant, you may want to take a home pregnancy test. These tests are designed to detect the presence of human chorionic gonadotropin in a sample of your urine. This hormone becomes detectable in urine once the embryo has implanted in the uterus, typically about 8 or 9 days after fertilization.

Image of a pregnancy test

Image of a pregnancy test

Whether your home pregnancy test is positive or not, a visit to your healthcare provider can confirm if you are pregnant. Much like the home pregnancy test, this is usually done by testing a urine sample or blood sample for human chorionic gonadotropin (HCG). Your healthcare provider may also perform a physical exam of your uterus and cervix, looking for other physical signs that you are pregnant. For example there may be signs that your uterus has enlarged, that your cervix is larger and softer, or that your cervix is blueish in colour. Less commonly, and usually only if you are experiencing vaginal bleeding or abdominal pain, your healthcare provider may recommend a transvaginal ultrasound to confirm whether you are pregnant. The earliest observable pregnancy-related change that can be seen with ultrasound is the development of a gestational sac. Later, ultrasound images are commonly used to monitor fetal development over the course of pregnancy.

Illustration of an ultrasound

Illustration of an ultrasound

Once you know for sure that you are pregnant, you can calculate an approximate delivery date for when your baby will be born; usually accurate to within a couple of weeks. As the exact day your egg was fertilized is difficult to pinpoint, the beginning of your pregnancy is usually taken to be the first day of your last normal menstrual period.

Physiological changes that occur during pregnancy

Hormonal: The menstrual cycle refers to the normal changes in your ovaries and uterus that make an egg accessible for fertilization and prepare your uterus for pregnancy. It typically occurs once every 28 days. If you are ovulating normally, an egg, or ovum emerges from one or other of your ovaries, leaving behind a structure called the corpus luteum. This structure produces large amounts of progesterone and estrogen, hormones that help prepare your uterus for implantation of a fertilized egg. If the egg is not fertilized, the corpus luteum degenerates, causing progesterone and estrogen levels to drop, and menstruation to begin. If the ovum is fertilized, on the other hand, the corpus luteum remains intact and continues to maintain the hormone levels you need to keep your uterus baby-friendly. Eventually, the placenta develops the ability to secrete the necessary hormones itself, and the corpus luteum typically disappears after 3 to 4 months.

In addition to progesterone and estrogen, human chorionic gonadotropin also spikes in early pregnancy. The levels of this hormone double every two days in the first 10 weeks of pregnancy. Its primary role is to prevent any further menstruation, and to prepare the placenta - the organ that connects the fetus to the uterus. The placenta allows the fetus to be supplied with nutrients and oxygen, as well as providing a route for the removal of toxic waste products.

Graph showing relative hormone concentration during each week of pregnancy

Graph showing relative hormone concentration during each week of pregnancy

Although many signs and symptoms of pregnancy are related to hormonal changes, there are also many that occur due to the growing fetus invading the spaces that were previously occupied by your other organs.

Image of the movement of organs to accommodate a growing fetus

Image of the movement of organs to accommodate a growing fetus

Immune tolerance: Your growing fetus is a foreign object, something that your immune system is normally programmed to attack and reject. In order to prevent this from happening, as soon as the embryo becomes implanted in the uterine wall, a key pathway that usually triggers the launch of an immune attack is turned off, making this part of your immune system dormant, and preventing immune cells from targeting the fetus or placenta. In addition to making it possible for you to grow your baby, there can be secondary benefits of pregnancy-related changes in immune function. In particular, women suffering from diseases caused by immune disorders, such as rheumatoid arthritis, multiple sclerosis, and psoriasis, may find relief from disease symptoms during pregnancy due to increased levels of anti-inflammatory steroids that occur naturally.

Cardiovascular: During pregnancy, your cardiac output - the amount of blood your heart pumps around your body per minute - increases to meet the needs of the developing fetus, and to provide the volume of blood necessary to fill the uteroplacental circulation.

Image of placental circulation

Image of placental circulation

This is achieved by increasing the stroke volume, which is the amount of blood pumped out of your heart with each heartbeat. Your cardiac output peaks around week 24 of your pregnancy, when it is 30%-40% higher than normal. As the fetus grows, your uterus begins to crowd your aorta, the major artery that carries oxygenated blood to your tissues and organs and vena cava, the major vein that carries deoxygenated blood back to your heart. Sometimes, certain positions, such as lying on your back, puts excess pressure on these vessels, which can lead to a drop in blood pressure causing dizziness, fainting, and in some cases, even damage to the fetus. In addition, exercise or activities that change heart rate tend to put a greater demand on your cardiovascular system when you are pregnant than they normally would, and the large changes in cardiac output associated with pregnancy may add additional strain for women with pre-existing heart conditions, such as valvular heart disease, or coronary heart disease. One other relatively common cardiovascular complication of pregnancy is varicose veins, which are enlarged, swollen veins that typically develop in the legs. During pregnancy, your growing uterus puts pressure on your veins making it harder for the blood to flow back to your heart. This causes the blood to pool in the veins making them swell.

Image of fetal placement while lying on your back versus lying on your side

Image of fetal placement while lying on your back versus lying on your side

Hematologic: As cardiac output increases, blood volume increases to match. This is due to a 50% increase in the volume of your plasma (the clear, yellowish fluid of your blood), and a 20% increase in the number of red and white blood cells. Overall, this has the effect of diluting the blood, often resulting in “physiological anemia of pregnancy” (a relative deficiency of red blood cells). Iron requirements increase during pregnancy as the fetus and placenta grow, and as the red blood cell numbers rise. Iron is essential for red blood cell production, and supplements are often needed as the amount of iron absorbed from the diet and recruited from iron stores is often not enough. Several hormones are thought to play a role in changing blood composition to support pregnancy including the renin-angiotensin-aldosterone hormonal system, atrial natriuretic peptide, estrogen, and progesterone, although exactly how they do this is not clear. Whatever the mechanism, the increased blood volume is very important as it ensures that the extra blood needed to supply the growing uterus and placenta is available, and can help protect the mother against normal blood loss that occurs while giving birth.

Image of red blood cells normally versus during anemia

Image of red blood cells normally versus during anemia

Renal: Your kidneys are responsible for filtering waste products from your blood, and regulating blood pressure and electrolytes; for example, sodium (Na

 start superscript, plus, end superscript), potassium (K

 start superscript, plus, end superscript) and calcium (Ca2

 start superscript, plus, end superscript). During pregnancy, changes in kidney function approximately follow changes in cardiac function - both organs work considerably harder. By around the 20th week, and sometimes as early as the 8th to 10th week of pregnancy, your kidneys are filtering 30% to 50% more blood than before you were pregnant. The effects of this are greater reabsorption of sodium, and increased elimination of sugars (glycosuria), amino acids (aminoaciduria), and creatinine in your urine (creatinine clearance tests are often used by doctors as a measure of how well your kidneys are working). After about the 12th week of pregnancy, progesterone, a smooth muscle relaxant, causes the tubes that transport urine from the kidneys to the bladder, called the ureters, to dilate. As your uterus expands, it may compress the dilated ureters, obstructing the flow of urine to your bladder, and increasing the chances that you get a urinary tract, or kidney infection while you are pregnant. Laying down on your side can help relieve the pressure on your major blood vessels letting your kidneys work more effectively. However, this can make for a lot of urine production and toilet breaks during the night when you are trying to sleep.

Respiratory: Breathing exercises are often practised by expectant mothers to use during labour and birth, but this isn’t the only way changes in respiration are helpful. As with your other organs, the growing uterus begins to invade the space normally reserved for your lungs, which restricts their expansion during normal breathing. Once again, progesterone, the multi-talented pregnancy hormone gets to work, triggering your lungs to increase the amount of air inhaled with each breath - the tidal volume - as well as the number of breaths per minute - the respiratory rate.This increases the oxygen supply required to meet the metabolic needs of the fetus, placenta and other organs.

Image of respiratory rate volume versus time

Image of respiratory rate volume versus time

Metabolic: Changes in metabolism during pregnancy alter the distribution of body fat, as well as how you digest and process food. While accumulating fats and nutrients is necessary for the healthy growth of your baby, metabolic changes can also affect the way in which medications are processed. As such, it is important to know how your pregnant body may respond to any drugs or homeopathic remedies you may be taking, and whether or not this could have an effect on your growing baby.

Body weight: Supporting the growth of a developing fetus takes a lot of energy, so it’s not surprising that more calories are required during pregnancy. In fact, after the first three months (trimester) your appetite generally increases so that you are consuming about 300 extra calories a day. Although in the first trimester you can expect to gain just a few pounds, it’s normal to gain about a pound per week for the rest of your pregnancy. In addition to weighing more, you can expect your breasts to grow around 1 to 2 cup sizes in preparation for breastfeeding.

Gastrointestinal: As your uterus grows, it puts pressure on your digestive organs including your colon, gallbladder, liver, and stomach. This can impair their function, and lead to constipation, gallstones, reduced bile transport, as well as a general slowing of the digestive process that is related to lower levels of the hormone gastrin. Gastrin stimulates the secretion of stomach acid, which in turn leads to the production of pepsin, an enzyme that digests proteins in your food - less gastrin leads to slower digestion. In addition to this, elevated progesterone levels during pregnancy slacken the cardiac sphincter, the “door” between your esophagus and stomach, making it open more easily. It is very common to experience heartburn due to acid reflux into your esophagus during the third trimester, as the cardiac sphincter cannot withstand the pressure that builds up in your stomach as your uterus grows. Its also worth noting that taking analgesics during pregnancy may not be for the best, as they can slow down gastric emptying even more, creating an even higher pressure that the cardiac sphincter must withstand.

Image of the stomach

Image of the stomach

Musculoskeletal: Numerous anatomical and physiological changes occur during pregnancy that strain the muscles and skeleton, particularly the pelvis, and which may lead to lower-back pain, leg cramps, and hip pain. One of the hormones responsible for musculoskeletal changes during pregnancy is relaxin, which softens your ligaments and cartilage tissues to help your body accommodate your growing baby. In addition to relaxin’s relaxing effects, the arrangement of the abdominal muscles themselves is particularly well adapted for childbearing. Unlike in men, where they form a “six pack”, women’s abdominal muscles are positioned to allow them to stretch around a baby-bump.

Image of abdominal muscles

Image of abdominal muscles

Integumentary: The integumentary system consists of your skin, hair and nails, as well as underlying connective tissue that attaches your skin to your body and various glands including sweat and oil producing glands, and your mammary glands. As your pregnancy proceeds, your skin stretches to accommodate your growing uterus and breast tissue. Sometimes the stretching can tear the underlying connective tissue causing red or purple marks to appear on your abdomen, commonly known as stretch marks. In addition, increased estrogen levels during pregnancy increases the production of melanin, the pigment that gives human skin and hair its color. This often causes the ring of colour around your nipples (areolae) to darken, and may create a line of pigment that typically runs from your navel to your pubic bone. Its also possible you may develop patchy discoloration of your face and darkening of any moles and freckles. Other integumentary changes that may occur during pregnancy include accelerated nail growth and excessive hair growth in unusual places, while increased blood supply to your skin often leads to increased perspiration. Finally, while it’s commonly said that pregnancy makes your skin clear and radiant, it’s also possible for it to become oily and acne prone.

Prenatal care

Why is prenatal care important? Prenatal care exists to help you and your baby be as healthy as possible. It is a good idea to visit your healthcare provider as soon as you think you might be pregnant, as they can help you identify and avoid any possible issues that may affect your health or the health of your baby. Regular check-ups throughout your pregnancy help your healthcare provider to spot and treat any problems early on, and give you an opportunity to discuss things you can do to give your baby the best start in life.

Consider the following:

Your body undergoes massive changes to support and nourish a baby, and after giving birth, it generally takes some time for you to feel like yourself again. Some body changes that persist may take you by surprise, but are all linked to the physiological changes that were necessary to grow your baby. These are some of the most common ones:

Low sex drive - this is linked to the abrupt drop in estrogen levels after you give birth. Your sex drive will come back, but don’t be surprised if sex stays a low priority for you for the better part of a year.

Tummy bulge - it takes 6-8 weeks for your uterus to shrink back to your pre-pregnancy size, meaning the tummy bulge may stick around for a while.

Shoe size - you may notice that your feet swell during pregnancy, but for some women carrying the extra weight around permanently alters their shoe size. This is likely related to the effects of relaxin, which loosens the ligaments throughout your body including your feet. The extra weight during pregnancy can flatten your arches, making your feet grow.

Breast size - although your breasts will grow during pregnancy and remain larger during breast feeding, it’s not uncommon for them to shrink to a slightly smaller size than they were before you were pregnant. This is usually related to your body weight, as the size of your breasts depends on the amount of body fat you have.

Hair loss - you may find your hair starts falling out faster than ever before during the months following childbirth. Estrogen slows the rate of hair loss during pregnancy, which means lots of hair is ready to drop when estrogen levels return to pre-pregnancy levels.

Menstruation - if you decide not to breastfeed your baby, you are likely to start menstruating (and ovulating) again about 10 weeks after giving birth, as your hormones return to their pre-pregnancy levels. However, it’s worth noting that your period may return the very next month after giving birth. Breastfeeding generally delays ovulation, so if you decide to breastfeed you may not have a period for up to 20 weeks or more, although it's also not uncommon for it to restart earlier than this.