

Detoxification & Nutrition in Pregnancy

by

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Question: I am planning to conceive after one year. Do you recommend undergoing detoxification & nutritional programs before I attempt to conceive?

Answer: A lot of young women face substantial discomfort (nausea / vomiting) especially during the 1st trimester of their pregnancy. This is due to the body trying to eliminate toxins in order to create a clean terrain for the development of a healthy fetus. Thus women with higher levels of accumulated toxins face more discomfort than others. This is one of the auto detoxification processes that nature has provided women. Vomiting is recognized as one of the standard detoxification procedures in Ayurveda and is known as Vamana.

It would be prudent to begin the process of detoxification at least one year prior to the planned date of conception. It would also be advisable at this stage to run a few blood tests such as Renal Profile, Liver Function Test to determine the efficiency of these organs and the build up of toxins therein. Follow-up testing after an elaborate detoxification program will help establish the efficacy of the detoxification process.

For more information please visit:

<http://www.space-age.com/detox.html>

It's also recommended to check CBC, serum iron, ferritin, serum zinc, copper, magnesium, calcium, phosphorous, electrolytes and numerous vitamin levels to ensure that these are not at marginally lower levels. A lot of nutritional reserves are used up during the pregnancy. It would therefore be prudent to use this one year period, prior to the planned date of actual conception, to work to bring these nutritional levels to their Optimum Levels (at the higher end of their Standard Reference Range). For more information please visit:

<http://www.space-age.com/pathology.pdf>

A lot of nutritionally depleted young women who go into pregnancy find to their utter dismay, their bodies manifesting symptoms of high blood pressure and / or diabetes during the 3rd trimester of the pregnancy. This invariably means resorting to putting prescription drugs (chemicals with multiple known side effects) into their body (and subsequently the fetus), and / or facing the risk of premature delivery. Worse still could be ending up with postpartum depression right after delivery when the baby needs you the most.

An increasing number of cases of postpartum depression and hormonal imbalance are being reported nowadays. Zinc deficiency results in hormone imbalance / hypothyroidism. This results in symptoms of mental confusion, depression, suicidal tendencies, anger, irritability, irrational behavior and the consequential inability to quickly release the weight put on during pregnancy. Normal breast feeding during the first year should easily accomplish this weight loss. Chromium deficiency also results in higher levels of serum insulin and the subsequent accumulation of body fat

and an inability to release body weight. Furthermore, low ferritin levels are also known to increase hair loss during pregnancy. All this can also happen during the lactation period when the daily nutritional requirements of the baby are going up by leaps and bounds.

The scary part could be that a nutritionally depleted mother would unknowingly pass on her nutritional deficiencies to her child at birth, who may then have to grow up with the hardships associated with these nutritional deficiencies.

A case in point:

Many mothers enter pregnancy with hemoglobin levels in the range of 10.00 to 12.00 g/dL. No attempt is made to check the serum iron or ferritin (intracellular reserves of iron) levels to assess the iron reserves in the body.

Many a times, the attending OB/GYN assures them that **“nothing will go wrong”** as they have handled thousands of such cases with lower hemoglobin in the past and it was not dangerous for the mother nor the child. But the question here is, **“will everything go right”?** Will my baby turn out to be bright and intelligent in school or will my baby be called “stupid” because of iron deficiency and suffer the onslaught of scolding from parents and teachers because of being **“so stupid”?** Children with iron deficiencies are known to have disorders in learning and other skills and often suffer ridicule from fellow classmates .

Note:

If you were to enter pregnancy with Hemoglobin 12.0 g/dL (and unmonitored serum iron and Ferritin levels), it is most likely that with each passing trimester, your Hemoglobin levels will steadily go down, especially if you were put on prophylactic doses of iron supplementation, since these are not capable of raising serum Ferritin levels. It is entirely probable, that in the 3rd trimester your Hemoglobin will have plummeted down to 10.5 g/dL (in spite of such supplements), and you may end up beginning breast feeding your baby with such low Hemoglobin levels. The end result will be that you will pass on your iron deficiency / anemia to your baby.

Children with Iron deficiency

Children with iron deficiency anemia perform more poorly in cognitive and motor skills tests and show delayed social and emotional development. Anemia also affects physical growth and mental development. Other consequences—including reduced levels of energy and productivity and impaired immune system function—develop as children mature. Even before they are deficient enough to get anemic, children who are iron deficient, are associated with a decrease in attention span, alertness, and learning ability. Memory and school performance are decreased. Athletic performance suffers. Kids with anemia tend to get sick more often. Prolonged or severe anemia can cause marked irritability, decreased appetite, and delayed growth. Untreated anemia can cause physical and mental delays in infants and children in areas such as walking and talking.

Each pregnancy depletes 500 mg to 1000 mg of iron from the reserves of the mother’s body. This means that, in order not to pass on iron deficiency to her new born baby, the ferritin (intracellular iron reserves) in the mother’s body should be brought up to 200 ng/mL, with a corresponding hemoglobin of 14.5 g/dL prior to the date of planned conception.

Anemia Profile - Females			
	Hemoglobin	* Serum Iron	** Ferritin
Standard Reference Range	11.5 to 15.0 g/dL	43 to 150 µg/dL	10 to 291 ng/mL
Optimum Value	14.5 g/dL	100 µg/dL	200 ng/mL
Anemia Profile - Males			
Standard Reference Range	12.5 to 17.0 g/dL	43 to 150 µg/dL	10 to 350 ng/mL
Optimum Value	16.5 g/dL	100 µg/dL	250 ng/mL
Note: * Ensure Optimum Values of Creatinine at 0.8 mg/dL and Serum Uric Acid at 4.0 mg/dL. Serum Iron levels tend to show falsely elevated values in case of some kidney insufficiency. ** Optimum Value of Ferritin is determined after optimizing serum B ₁₂ levels to ≈ 800 pg/mL. Poor levels of B ₁₂ (typically in the 200 to 400 pg/mL range) tend to show falsely elevated values of Ferritin which can be quite misleading.			

Serum Ferritin

Serum ferritin concentrations of 70 ng/mL or greater are required to stop hair fall, while 100 ng/mL or greater are required to stop greying hair and promote hair regrowth.

Critical Ferritin Levels at which Chronic Anemia passes over to Acute Anemia = typically below 50 ng/mL

Optimum Value of Ferritin for Females = 200 ng/mL

Optimum Value of Ferritin for Males = 250 ng/mL

Therapeutic dose of Intracellular Organic Iron required to be given to correct Ferritin levels below 50 ng/mL:

100 mg Elemental Iron with other supporting Nutrients when orally delivered at **Intracellular levels**, bid, for **minimum of six months** will help to raise below critical levels of Ferritin to above 100 ng/mL.

Around this time please do a CBC, Serum Iron and Ferritin Test after discontinuing all Iron supplements for a **minimum period of 7 days**.

Continue Iron supplements thereafter till Ferritin reaches Optimum Values given above.

Do not use prophylactic doses of Iron designed to work at serum levels to correct Ferritin levels. These formulations typically containing Ferrous Sulfate are not designed to penetrate intracellular spaces to correct Ferritin Values.

Taking prescription strength therapeutic doses of nutritional supplements like zinc, magnesium, calcium, chromium etc., especially designed to alter intracellular levels will help to correct these type of nutritional deficiencies given a period of 6 to 12 months.

Nutritional deficiency passed on from mother to child at birth can result in health challenges later on in life as the child grows up and reaches adulthood. For example, magnesium deficiency is known to cause convulsions in babies and high

blood pressure later on in their life; and chromium deficiency has the propensity to cause type 2 diabetes later in life.

It is equally important to understand the need to have digestion working at peak efficiency in order to ensure that the nutrition being administered orally and through diet is being absorbed and retained in the body.

Increasing the flow of gastric juices (e.g. hydrochloric acid in particular) will ensure proper digestion of food in the stomach and the extraction and absorption of the nutrition from the food we eat and nutritional supplements we take. Next we need to detoxify the liver in order to ensure proper flow of bile into the small intestines where further digestion and basic absorption of nutrition will occur.

The enzyme flow from the pancreas must also be increased to ensure the digestion of proteins, carbohydrates and fats from the food we eat.

Rejuvenation of the entire digestive system is recommended prior to the date of planned conception. This will also speed up the entire digestive process and automatically reset the body's biological clock to give two bowel motions, one in the morning and one at bedtime.

Detoxification and rejuvenation of the whole body will ensure minimal discomfort during pregnancy and a healthy baby, with minimum medical complications during pregnancy and a lowered risk of postpartum depression.

Furthermore, the energy and nutritional levels of the mother will be maintained after delivery to ensure proper nurturing and optimum growth of the child.

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Map: www.space-age.com/Mumbai-Clinic-Map.pdf

FAQs

Question: Is there a way to reduce the effect of hereditary diseases?

Answer: We know that nutritional deficiencies do pass from mother to baby. It is now well understood that a lack of some nutrients like magnesium, zinc, chromium, to name a few, are responsible for chronic diseases like hypertension and type 2 diabetes. It therefore clearly follows that the present thinking that these are “hereditary diseases” are actually nutritional deficiencies passed on from your maternal grandmother to your mother and then through you to your future baby.

For example, if your maternal grandmother was deficient in say Chromium, because say the soil conditions were poor in the geographical region she lived in, then your mother would also have inherited this deficiency, assuming she took no nutritional supplements all her life. It will then get passed on through you and then onwards to your planned baby.

You can break this cycle by taking care of your own nutritional deficiencies and making sure that the future generation is born healthy.

There is really no merit in the theory of “hereditary diseases” like high blood pressure, type 2 diabetes, other cardiac disease which have been wrongly classified as chronic diseases when they are merely symptoms of nutritional deficiency and are fully reversible in nature. For more information:

<http://www.space-age.com/aging.html>

The question therefore arises is, what really is hereditary. It is your “right to good health” as you can be born with a perfect body. How you maintain it thereafter is your choice.

Question: If it is so important for a potential mother to correct her nutritional deficiencies before planned conception, what role does my husband’s nutritional profile play in planning a baby?

Answer: Basically, as the fetus grows inside the womb, the nutrition of the mother is of prime importance and the only source of nutrition for the fetus.

The husband’s role here is only to provide healthy sperm and to provide emotional support for his wife.

However, it is important to understand that to conceive, the husband should have fairly good levels of testosterone to ensure, no erectile dysfunction and sustained erection to lead a normal sex life. Nutritional deficiencies in zinc, selenium, vitamin c, etc. are know to lower testosterone levels and the quality of the sperm creating fundamental problems in successful conception.

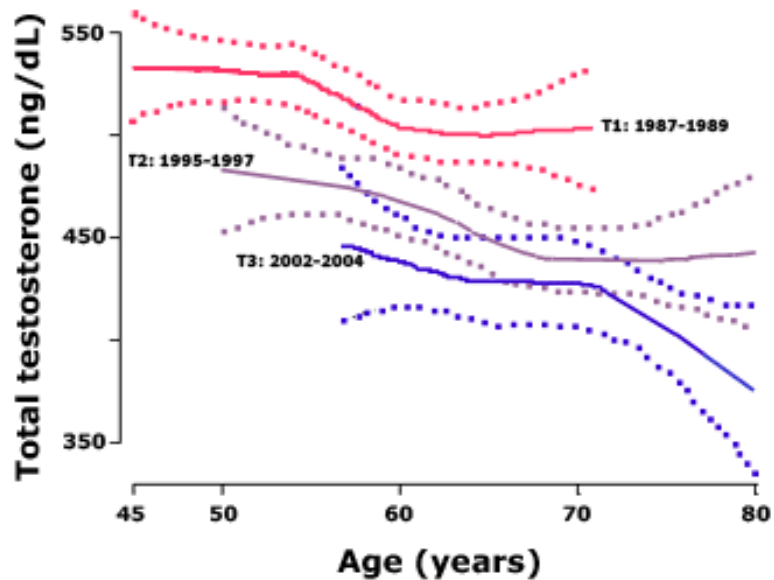
So it will be helpful if the husband is in fairly good health to deliver quality sperm for conception.

Here is a table showing optimum testosterone levels in males of different age groups. Maintaining testosterone at these levels will also aid to prevent premature aging and the onset of senility.

Testosterone	Standard Reference Range	Optimum Values
Total Testosterone	200-1200 ng/dL	26 - 35 yrs - 1200 ng/dL 36 - 45 yrs - 1000 ng/dL 46 - 55 yrs - 800 ng/dL 56 - 65 yrs - 800 ng/dL
Free Testosterone	8.69 to 54.69 pg/ml	25 to 50 pg/ml

Optimum Testosterone Levels in Males

An additional advantage and incentive for males to maintain above average testosterone levels, is that, it will make a marked difference in their professional life, (e.g. the speed, efficiency and precision with which decisions are arrived at and in their ability to deliver CEO level bottom line results in the corporate world). For more information: <http://www.space-age.com/andropause.html>



Declining Total Testosterone Levels over the years

With the over cultivation of agricultural land and declining nutritional levels in the top soil, it is clear that we are now no where close to the previously healthy standards for testosterone in males. With each passing year it is only getting worse. For more information please visit:

<http://www.space-age.com/nutri-farm-seminar.doc>

Today we have approximately 25% males in the age group of 20 to 35 years with exceedingly low testosterone levels, similar to those encountered in 75+ year old people. They have the physical body of a 25 year old, but the emotions, mental and muscular capacity of a 75 year old. This shocking fact is little know or spoken about in society. For more information please visit: <http://www.space-age.com/ed.pdf>

Question: I never knew about all these things before. I just had a baby six months back. Neither my gynecologist nor my pediatrician warned me about these things. Is there anything I can do about it now?

Answer: *“It is never to late to make amends”* – so the saying goes. If you are still breast feeding the baby you can start on doses of nutritional supplements as per your blood reports to build up your own depleted reserves and also to ensure that henceforth the baby gets enough nutrition from breast feeding. Nutrition is very important as the baby is now growing rapidly. I would also like to recommend that you regularly begin administering multivitamin cum mineral drops to the baby.

Watch the child as it grows up. Is it mentally sharp, has good memory retention and recall capabilities, and does not tire easily during physical exercises like crawling and trying to standup and walk or later on in life at school sports? Does the child’s physical stamina appear low compared to other above average kids in his age group? Are the grades obtained good and above average? Is the physical growth the same or equal to the above average kids in his age group?

Remember the rule: ***Vitamins create “expensive urine” in the absence of other supporting minerals.*** Use a malt based iron and multivitamin + minerals tonic during the growing years right up to high school.

Question: I have just entered the 3rd trimester of my pregnancy. My heart rate is very high, occasionally exceeds 100 beats per minute and I become breathless if I try to climb even one flight of stairs or engage in daily chores around the house. Is there anything that can be done nutritionally to ease my situation as I have another 3 months to go and would like to have a normal full term pregnancy?

Answer: What you have developed is medically known as tachycardia. This is principally a magnesium deficiency and the severity of these symptoms can be reduced substantially within a few weeks. Please use therapeutic doses of magnesium in an organic compound form like a lactate, gluconate, orotate, aspartate, ascorbate, etc. to quickly resolve this situation.

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Some Unique Case Studies

Arpita – A Child Born With Neuromuscular Dysfunction is Good at High Jumps!

History:

Arpita is a young girl 12 years old who has been diagnosed with mild dyslexia and weak neuromuscular co-ordination. She also suffers from leg / muscle cramps and poor concentration. She has developed a stooping posture since early childhood.

In spite of these physical challenges, she is a sports person who excels at High Jumps at school level. Her mother and her two aunts are MDs in various specialties of medicine and believe, due to general consensus in the medical fraternity they belong to, that these are congenital defects and are therefore untreatable.

Our Observations:

Due to history of poor concentration and leg / muscle cramps, it was decided to check her ferritin levels to determine the existence of chronic anemia at intracellular levels, which most probably could have easily been passed on from mother to daughter at child birth.

Her blood report showed her hemoglobin was only 11.2 g/dL, while her serum ferritin was only 8.60 ng/mL, against an optimum level of 14.5 g/dL and 200 ng/mL respectively found in healthy people. The prior diagnoses of chronic anemia since birth and now confirm through a blood report could easily explain “mild dyslexia” (learning disorder) which was observed since childhood in Arpita. Since the Ferritin levels were well below 50 ng/mL the diagnosis of chronic anemia was now classified as a more severe acute anemia. Please refer to note on Dietary Anemia attached to this case study.

Her stooping posture and prior diagnoses of weak neuromuscular co-ordination was a dead give away of a serious intracellular magnesium deficiency. In spite of these odds Arpita could high jump about 1.30 meters (4ft 3 inches) and had secured position 3 at school level.

During a routine check up at our health center we found;

On November 09, 2011

BP = 97 / 56 Pulse P = 71

BPs (standing) = 98 / 53 Pulse Ps = 67

We noticed a fall in both her diastolic blood pressure and heart rate on exercising (standing up). This reflected poor cardiac efficiency.

On checking her blood pressure, heart rate and cardiac efficiency it became apparent that the earlier diagnoses of neuromuscular disease was actually a serious magnesium deficiency which was also clearly evident because of her stooping posture. Her heart rate fell on exercising, an indication of poor cardiac efficiency. A routine blood report further confirmed serum magnesium deficiency (1.97 mg/dL) against an optimum level of 2.4 mg/dL found in healthy people.

Since calcium helps muscles contract and magnesium helps muscles relax, it was highly probable that once the serum and erythrocyte magnesium levels were raised to optimum levels, Arpita's performance at high jump would improve substantially and would allow her to progress from school to district / state level and then to national level participation. Also,

raising her hemoglobin levels to an optimum of 14.5 g/dL and ferritin to 200 ng/mL would improve her oxygenation level and allow her to perform better at a sport she was naturally good at.

Her Progress:

Her poor cardiac efficiency mentioned above was hampering her reaching her full potential as a sports person.

She was immediately put on therapeutic doses of organic magnesium (fortified with other supporting nutrients) and organic iron (fortified with other supporting nutrients) which were carefully formulated to work at quickly altering intracellular values.

Within 2 weeks of beginning intracellular magnesium therapy with other supporting nutrients, the stooping posture had magically disappeared and she was standing erect and tall for the first time in her life.

A few months later I got an e-mail (On 5/26/2012) from her mother:

" Arpita is doing well. She got gold medal in high jump with a performance of 1.38 meters (4 ft. 6.5 inches) at district level and has been selected for state level. " -:)

In May 2012 Arpita got a Gold Medal at District level - 1.38 meters (4 ft. 6.5 inches)

In September 2012 she got a Gold Medal at State level - 1.40 meters (4 ft. 7.5 inches)

On September 24, 2012 an excited mother called to tell me Arpita won Gold at National Level - 1.46 meters (4ft. 9.5 inches). Some more events are in the pipe line for this gifted under 14 year old.:-)

We wish her all the best.

On March 11, 2013 (15 months later)

Hemoglobin had increased from 11.2 g/dL in Nov 2011 to 12.9 g/dL

Ferritin had increased from 8.60 ng/mL in Nov 2011 to 179.15 ng/mL

Serum Magnesium had increased from 1.97 mg/dL in Nov 2011 to 2.12 mg/dL

On October 05, 2013

BP = 105 / 67 Pulse P = 64

BPs (standing) = 106 / 66 Pulse Ps = 67

Here we now see a slight increase in heart rate on exercising. Optimum would be if both the systolic / diastolic blood pressure and heart rate would increase by 10 to 15 points on exertion.

We still have a long way to go to bring Arpita's body to perfection, as would be required by a sports person. Hopefully, we can do this next year, after Arpita graduates from high school and can devote more time to health care and sports.

Short Note on Chronic / Acute Anemia

Anemia Profile - Females			
	Hemoglobin	* Serum Iron	** Ferritin
Standard Reference Range	11.5 to 15.0 g/dL	43 to 150 µg/dL	10 to 291 ng/mL
Optimum Value	14.5 g/dL	100 µg/dL	200 ng/mL
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Note:			
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** Optimum Value of Ferritin is determined after optimizing serum B ₁₂ levels to ≈ 800 pg/mL. Poor levels of B ₁₂ (typically in the 200 to 400 pg/mL range) tend to show falsely elevated values of Ferritin which can be quite misleading.			

Serum Ferritin

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Critical Ferritin Levels at which Chronic Anemia passes over to Acute Anemia:

Ferritin typically below 50 ng/mL

Optimum Value of Ferritin for Females = 200 ng/mL

Optimum Value of Ferritin for Males = 250 ng/mL

Therapeutic dose of Intracellular Organic Iron required to be given to correct Ferritin levels below 50 ng/mL:

100 mg Elemental Iron with other supporting Nutrients when orally delivered at Intracellular levels, bid, for minimum of six months will help to raise below critical levels of Ferritin to above 100 ng/mL.

Around this time please do a CBC, Serum Iron and Ferritin Test after discontinuing all Iron supplements for a minimum period of 7 days.

Continue Iron supplements thereafter till Ferritin reaches Optimum Values given above.

Do not use prophylactic doses of Iron designed to work at serum levels to correct Ferritin levels. These formulations, typically containing Ferrous Sulfate, are not designed to penetrate intracellular spaces to correct Ferritin Values.

Calcium interferes with absorption of iron. Calcium supplements or high intake of dairy products which are a rich source of calcium can cause iron deficiency anemia.

Problems with pregnancy: Maternal iron deficiency can have significant consequences for the development of unborn child. A retrospective analysis conducted by the Centers for Disease Control and Prevention found an increased risk of preterm birth in mothers with low hemoglobin levels during the first two trimesters of pregnancy. In non-African American women, moderately low maternal hemoglobin, defined as 9.0<10.0 g/dL during the first trimester and as 8.5<9.5 g/dL during the second trimester, also was associated with a higher risk of still birth. In addition, women with hemoglobin <10 g/dL during the first twelve weeks of pregnancy had a three-fold greater risk than their non-anemic counterparts of giving birth to an infant with low birth weight.

Iron deficiency during gestation and lactation also is associated with changes in nervous system development and functioning. Possible complications in a pregnant woman with iron deficiency anemia are premature labor, dangerous anemia from blood loss during labor requiring blood transfusions and increased susceptibility to infection after childbirth.

Problems in children: Children with iron deficiency anemia perform more poorly in cognitive and motor skills tests and show delayed social and emotional development. Anemia also affects physical growth and mental development. Other consequences—including reduced levels of energy and productivity and impaired immune system function—develop as children mature. *Even before they are deficient enough to get anemic, children who are iron deficient, are associated with a decrease in attention span, alertness, and learning ability.* Memory and school performance are decreased. Athletic performance suffers. Kids with anemia tend to get sick more often. Prolonged or severe anemia can cause marked irritability, decreased appetite, and delayed growth. Untreated anemia can cause physical and mental delays in infants and children in areas such as walking and talking.

(The symptoms of Aripta – dyslexia (learning disorder), poor concentration, are marked in red italics above to show that it was not a congenital defect by just acute anemia and could be corrected through Orthomolecular Medicine i.e. nutrition administered at intracellular levels. Iron deficiency was also affecting her athletic performance.)

Blessings,

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