**City and Hackney Nausea and Vomiting in Pregnancy and Hyperemesis gravidarum guidelines**

* The majority of women vomit or feel nauseated in early pregnancy. It usually begins between the 4th and 7th weeks and resolves by 20 weeks gestation
* If nausea and vomiting starts in the second or third trimesters then this is a red flag and needs investigation
* Hyperemesis gravidarum (HG) is a diagnosis of exclusion and causes prolonged and severe nausea and vomiting with dehydration, ketosis, >5% weight loss and electrolyte imbalance
* HG is often due to increased HCG levels, for example, in multiple pregnancy and hydatiform moles. HCG has TSH-like activity so may result in hyperthyroidism that is self-resolving after the first trimester. If hyperthyroidism is detected then it should be managed conservatively unless it is persistent or severe
* HG affects up to 1% of pregnant women. Patients with HG require hospitalisation in order to correct the dehydration, electrolyte and metabolic disturbances, to prevent further weight loss, to re-establish oral intake, and to prevent the complications of HG.
* It is important that women with simple nausea and vomiting in pregnancy (NVP) are distinguished from women with HG. The majority of women with mild NVP are able to manage themselves by learning which particular foods to avoid to minimise symptoms and to eat at the time of the day when their nausea is less severe. If these women present for medical attention, they should be managed as outpatients by simple measures with the addition of antiemetic medication if required.

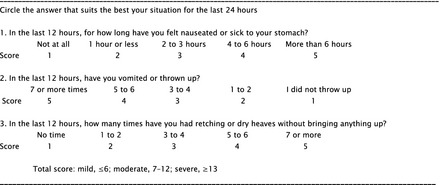
**Assessment of nausea and vomiting in pregnancy (NVP):**

* History
  + Previous NVP or HG
  + Exclude other causes
    - Abdominal pain
    - Urinary symptoms
    - Infection
    - Medications e.g. iron
    - Helicobacter pylori
  + PUQE score\*
* Examination
  + Temperature, pulse, BP
  + Abdominal examination
  + Weight
* Investigations
  + Urine dipstick
  + Urine MC&S
  + Consider bloods for U&Es, FBC, glucose, TFTs, LFTs
  + Consider USS for multiple pregnancy/mole

**Differential diagnosis:**

* GU – UTI, pyelonephritis, ovarian torsion
* Endocrine – thyrotoxicosis, DKA, Addison’s
* GI – gastritis, peptic ulcer, pancreatitis, bowel obstruction, hepatitis, gallstones, appendicitis
* Neurological – vestibular, migraine
* Other pregnancy related conditions, e.g. pre-eclampsia

**PUQE score:**



**Management:**

* PUQE score 3-12 + no complications → oral anti-emetics and lifestyle and diet advise
* PUQE score ≤ 13 + no complications and no improvements with anti-emetics → refer to OMU
* Any PUQE score with complications or unsuccessful trial at OMU → inpatient management

Community management:

* Dietary measures such as avoiding greasy food and having frequent small meals, drinking little and often.
* Eating at times of the day when nausea is less severe and eating before getting out of bed in the morning have been found to be helpful.
* Avoidance of the smell of food, including eating cold rather than hot food and minimising time spent in the kitchen may reduce symptoms.
* The importance of drinking small amounts of fluid regularly between meals should be stressed.
* Iron supplements should be temporarily discontinued as are a common cause of nausea and vomiting.
* Non-pharmacological measures such as ginger and P6 accupressure
* Pharmacological management with oral anti-emetics. No drug is currently licensed for the treatment of nausea and vomiting in pregnancy in the UK. However, there are extensive data showing lack of teratogenicity with cyclizine, promethazine, prochlorperazine and metoclopramide
  + First line
    - Cyclizine 50mg TDS
    - Prochlorperazine 5-10mg QDS
    - Promethazine 12.5-25mg QDS
    - Chlorpromazine 10-25mg QDS
  + Second line
    - Metoclopramide 5-10mg TDS (but risk in young people of oculo-gyric crisis)
    - Domperidone 10mg TDS
    - Ondansetron 4-8mg TDS
  + Combinations of anti-emetics from different classes should be used in women who do not respond to a single anti-emetic

Refer to A+E if:

* Symptoms severe despite 24 hours of oral anti-emetics
* There is evidence of dehydration, >2+ of ketones in urine or suspicion of a medical complication
* If HG is suspected refer the patient to gynaecology on bleep 005 via A+E

Management strategies that are **NOT** recommended:

* Herbal treatments
* Homeopathy
* Hypnosis
* Hypnotherapy
* Psychotherapy
* Multivitamins - except in hyperemesis where vitamin B1 has been advised

**Follow up**

* Those admitted to OMU will be followed up by EPAU within 24 hours
* Check psychological wellbeing, signpost to [www.pregnancysicknesssupport.org.uk](http://www.pregnancysicknesssupport.org.uk)
* Consider early anti-emetic use in future pregnancies
* If NVP continues into second and third trimesters then the woman may need review in hospital antenatal clinic with monitoring of fetal growth and maternal wellbeing.

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Review date: January 2023