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Belfast Health and Social Care Trust
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Policy Code: BHSCT/MDES/Mat (09) 2025

Title:	**Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum**			
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Responsible Director:	[redacted] Director Child Health & NISTAR/Maternity, Dental, Gynae & Sexual Health Services			
Policy Type: (tick as appropriate)	*Directorate-specific ☒	Clinical Trust wide ☐	Non-clinical Trust wide ☐	Regional Policy ☐
If ***Directorate-specific** please list the name and date of the local Committee/Group that policy was approved		Does this policy have Workforce implications? **N**		
Name: RJMS Patient Safety, Audit and Mortality Meeting **Date:** 15/05/2025		**Date:**		
Approval process:	Drugs and Therapeutics Committee Meeting Policy and External Guidance Assurance Committee Executive Team Meeting	**Approval date:**	27/06/2025 01/07/2025 28/07/2025	
Operational Date:	July 2025	**Review Date:**	July 2030	
Version No.	2	**Supercedes**	V 1 - Management of Hyperemesis Gravidarum: Oct 2014- October 2017	
Key Words:	Nausea and vomiting in pregnancy, Hyperemesis Gravidarum			
Links to other policies				

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Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum- flowchart of recommended antiemetic therapies

Note this is not a complete description of management.
See full policy for further guidance.

First presentation
If admission required– IV hydration as per guideline

Inpatient: Prescribe cyclizine 50mg IM/ IV TID
Discharge: Prescribe cyclizine 50mg PO TID

↓

Further presentation
If admission required– IV hydration as per guideline

Inpatient : addition of Prochlorperazine 12.5mg IM TID OR Metoclopramide 10mg IM TID if required- see guideline for cautions
Discharge: Prochlorperazine 10mg PO TID

Metoclopramide should not be prescribed for over 5 days

↓

Further presentation
If admission required– IV hydration as per guideline

Inpatient: Ondansetron 4-8mg BD IM/IV over 15mins – see guideline for cautions
Discharge: Xonvea-consider if failure to respond to 2 different antiemetic therapies from different classes
Ondansetron 4mg TID PO/8mg BD PO

↓

Women not responding to IV hydration and antiemetic therapies, or for protracted cases of hyperemesis gravidarum.

Consultant decision required for consideration of:
- Steroids
- Naso-jejunal feeding or TPN

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

NVP affects up to 85% of pregnant women. It typically starts between the 4th-7th week gestation, peaks around the 9th week and resolves by the 20th week in 90% of cases.
Hyperemesis gravidarum is the severe form of NVP and affects 0.3-3.6% of pregnant women.

1.2 Purpose

This guideline is designed for use for all staff involved in the care of pregnant women who present with nausea and vomiting in pregnancy (NVP) or hyperemesis gravidarum (HG).

1.3 Objectives

All staff should use this guideline in order to provide a high standard of evidence based care to women presenting with NVP and HG.

2.0 SCOPE OF THE POLICY

This policy provides guidance on the assessment, management and treatment of women with nausea and vomiting in pregnancy and hyperemesis gravidarum in the ambulatory care and inpatient setting.

3.0 ROLES AND RESPONSIBILITIES

All obstetricians, midwives and healthcare providers in BHSCT should use this guideline to provide a high standard of evidence based care for women with nausea and vomiting in pregnancy and hyperemesis gravidarum.

4.0 KEY POLICY PRINCIPLES

Women should be advised that they should contact the Maternity Assessment Unit (MAU) in Royal Maternity Hospital if they have concerns regarding symptoms of nausea and vomiting in pregnancy.
All women contacting the MAU should be triaged using the validated Pregnancy-Unique Quantification of Emesis-24 (PUQE) score and appropriate advice provided based on the severity of their symptoms.
NVP and HG are diagnoses of exclusion and other causes of nausea and vomiting should be ruled out.

4.1 Definitions

Nausea and vomiting of pregnancy should only be diagnosed when onset is in the first trimester of pregnancy (<12 weeks) and other causes of nausea and vomiting have been excluded.

4.2 Risk factors for NVP include;

- First pregnancy
- Multiple pregnancy
- Gestational Trophoblastic disease (GTD), including molar pregnancy
- Obesity
- History of migraines / motion sickness / nausea with oestrogen containing contraceptives
- Being seropositive for *Helicobacter pylori*
- History of HG in previous pregnancy
- Family history of NVP or HG

4.3 Other causes of NVP:

System	Conditions
Gastrointestinal	• Gastroenteritis • Gastritis • Peptic ulcer disease • Pancreatitis • Bowel obstruction • Hepatitis • Appendicitis • Gastroparesis • Cholecystitis
Genitourinary	• UTI • Uraemia • Pyelonephritis
Gynaecology	• Ovarian torsion
Metabolic/Endocrine	• Hypercalcaemia • Thyrotoxicosis • Diabetic ketoacidosis • Addison's disease
Renal	• Renal calculi
ENT	• Labyrinthitis
Neurological	• Migraine • Vestibular disease
Pregnancy related	• Acute fatty liver of pregnancy • Pre-eclampsia (consider if onset of NVP beyond 20wks gestation)
Drug-induced vomiting	• E.g. iron, opioids
Psychological	• Eating disorders

4.4 Diagnosis of Hyperemesis Gravidarum

HG can be diagnosed when there is severe protracted NVP unrelated to any other cause that is accompanied by the triad of:

- Weight loss (>5% of pre-pregnancy weight)
- Dehydration
- Electrolyte imbalance

4.5 Complications

Hyperemesis Gravidarum can lead to complications for both the mother and the fetus.

4.5.1 **Maternal Complications**

- Hypokalaemia (leading to lethargy, muscle weakness or cardiac arrhythmia)
- Hyponatraemia (leading to central pontine myelinolysis)
- Abnormal LFTs/ TFTs
- Wernicke's encephalopathy
- Vitamin B6/12 deficiency (leading to anaemia and peripheral neuropathy)
- Malnutrition
- Weight loss
- Mallory-Weiss tear
- Venous thromboembolism
- Psychological issues (e.g., anxiety, depression, suicidal ideation)
- Adverse effect on quality of life and mental health

4.5.2 **Fetal Complications**

- Growth restriction
- 40% incidence of fetal death with Wernicke's encephalopathy
- Placental dysfunction (association with second trimester HG)
- Preterm delivery

4.6 MATERNITY ASSESSMENT UNIT REFERRAL AND TRIAGE SYSTEM:

All women contacting the Maternity Assessment Unit with NVP should be triaged using the validated Pregnancy-Unique Quantification of Emesis-24 (PUQE) score. The PUQE score can be used to determine whether the NVP is mild, moderate, or severe and can be used to track progress with treatment. It may also help to identify women with HG.
Referral sources may include: self-referral, GP, emergency department, antenatal clinics, Out of Hours (OOH) GPs.

4.6.1 Pregnancy-Unique Quantification of Emesis-24 (PUQE) Score

1. On average in a day, for how long do you feel nauseated?

>6hrs	4-6hrs	2-3hrs	≤1hrs	Not at all
5	4	3	2	1

2. On average in a day, how many times do you vomit?

≥7 times	5-6 times	3-4 times	1-2 times	Not at all
5	4	3	2	1

3. On average in a day, how many times have you had retching?

≥7 times	5-6 times	3-4 times	1-2 times	Not at all
5	4	3	2	1

RED FLAG ASSESSMENT:

- **Inability to tolerate oral antiemetics / oral intake**
- **Unresponsive to outpatient management**
- **Co-morbidity and unable to take oral medications- epilepsy, diabetes mellitus, HIV, hypoadrenalism, psychiatric disorders**
- **Confirmed or suspected comorbidity such as UTI and unable to tolerate oral antibiotics**
- **Concern regarding mental health**

Mild NVP + **no red flags** ≤ 6: Refer to General Practitioner

Moderate NVP + **no red flags** ≤ 7-12: Refer to General Practitioner

Severe NVP ≥ 13: Advised to attend Maternity Assessment Unit, RJMS

Any red flags: Advised to attend Maternity Assessment Unit, RJMS

Following GP assessment if initial management options fail to control symptoms- onward referral can be made by GP to the Maternity Assessment Unit, RJMS either by telephone 02896150596 or letter.

4.7 Initial assessment

4.7.1 History

A thorough history should be taken from the woman and considerations given to the other causes of NVP. A medical or surgical cause of NVP must be ruled out. NVP with an onset ≥12 weeks' gestation is unlikely to be attributable to HG and another diagnosis should be suspected.

Specific features in the history that are important to ask about include:

- Date of the last menstrual period (LMP)
- Any previous history of NVP or HG
- Onset and frequency of vomiting
- PUQE Score
- Questions to exclude other causes:
    - Abdominal pain
    - Urinary symptoms
    - Other GI symptoms e.g., diarrhoea
    - Infection
    - Medication history

4.7.2 Examination

Examination should be performed to assess the woman's fluid status and to rule out the other causes of NVP e.g., UTI, gastrointestinal disease etc.

Specific examinations that should be performed in women with NVP include:

- NEWS score (temperature, pulse, BP, O2 saturation, respiratory rate, AVPU)
- Abdominal examination
- Weight (and height to calculate BMI)
- Signs of dehydration (see Table 1)
- Signs of muscle wasting
- Other examinations as guided by the history

Table 1. Signs and Symptoms of Dehydration

Symptoms	Signs
Poor oral intake	Dry mucous membranes
Reduced frequency of micturition	Tachycardia
	Sunken eyes
	Prolonged capillary refill time
	Weight loss
	Dark or concentrated urine

4.7.3 **Investigations**

On admission: all patients require:
- Urinalysis (+/- MSSU if clinically indicated- nitrates may indicate infection- presence or absence of ketonuria in pregnancy is **not** an indicator of dehydration)
- U&Es to identify electrolyte imbalance
- FBC and CRP to exclude infection
- Random blood glucose- if diabetic or risk of low blood sugar
- For diabetic patients, checking capillary blood glucose regularly is mandatory

4.7.4 **Other investigations:** you may wish to perform on the woman's first presentation or in refractory cases include:

- Pelvic ultrasound scan- confirm no. of fetuses, viability and gestational age- exclude multiple and trophoblastic – organize through Early Pregnancy Assessment (EPAU)
- Thyroid function tests (TFTs)
- LFTs
- Calcium, magnesium and phosphate
- Amylase
- Arterial blood gas (ABG) – if metabolic disturbances are suspected

4.7.5 **For inpatient cases:** daily monitoring of urea and electrolytes (U&E), full blood profile (FBP), capillary blood glucose monitoring (BM) and urinalysis.

4.8 Management

Women who have nausea and vomiting but are not clinically dehydrated can be managed in the community with antiemetics, oral rehydration and dietary advice and advised to re-present to her GP if symptoms worsen.
If women are unable to tolerate oral antiemetics or oral fluids and shows clinical signs of dehydration then ambulatory management via DOU should be offered.

Any existing medications should be reviewed and consideration given to stopping any non-essential medications which may be contributing to their symptoms e.g. iron supplements.

4.8.1 **Antiemetics**

A stepwise approach should be adopted when prescribing antiemetics involving medications from different classes. Prescribing medications from the same class is not advisable ie prescribing cyclizine and xonvea (both H1 antagonists) may increase anticholinergic side effects without therapeutic benefit. ie constipation and sedation.

If severe symptoms, first dose should be through IM/IV administration before switching to oral antiemetics once clinical improvement occurs. A combination of medications may be required to adequately control symptoms, ensuring there are no interactions between them.

- Xonvea (Doxylamine/Pyridoxine) is currently the only licensed medication for NVP for use in pregnancy in the UK. For the purpose of this guideline, the prescription of xonvea is reserved when symptoms have failed to respond to a trial of 2 different classes of medication.

- There is safety data for as anti (H1) histamines, phenothiazines and pyridoxine-doxylamine (Xonvea®). Cochrane review shows no increased risk of congenital malformations or other adverse pregnancy outcomes. Discuss risks and benefits with women.

Recommended antiemetic therapies and dosages

Flowchart recommended antiemetic therapies

First line

Cyclizine (H1 antagonist)	50mg PO, IM or IV 8 hourly
Prochlorperazine (Dopamine antagonist)	12.5mg 8 hourly IM/IV 5–10mg 6–8 hourly PO (alternative routes 3mg buccal, 25mg PR daily)
Doxylamine and Pyridoxine (Vitamin B6, H1 antagonist)	Day 1: 20/20mg PO, nocte for 2 days. Increased if necessary to day 3: 10/10mg PO mane, and 20/20mg PO nocte, increased if necessary to; day 4: 10/10mg mane, 10/10mg midday and 20/20mg nocte. Max dose 40/40mg per day

Prescribe Xonvea if failure to respond to treatment with 2 different classes of antiemetic medication.

Second line

Metoclopramide (Dopamine antagonist) 5–10mg 8 hourly PO, IV/IM/SC

- Metoclopromide should NOT be used for a period of more than 5 days
- Reduce dose of metoclopramide to 5mg TID for patients aged 15-19 years or under 60 kg body weight

http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON300404

- Avoid concomitant use of metoclopromide and prochlorperazine: increased risk of extrapyramidal symptoms and oculogyric crises.

Please note

Oculogyric crisis is an extrapyramidal reaction to prochlorperazine or metoclopramide.

Emergency treatment is procyclidine 5mg IM or IV repeated after 30 minutes if necessary

- IV doses for metoclopramide should be administered by **slow bolus injection** over 3 minutes to minimise risk of extrapyramidal effects

Ondansetron (5HT^3 receptor antagonist) 4mg 8 hourly or 8mg 12 hourly PO;

8mg over 15 minutes 12 hourly IV;
16mg daily PR

- Women taking ondansetron may require laxatives if constipation develops
- Hypokalaemia and hypomagnesaemia should be corrected before ondansetron administration.
- As per MRHA advice avoid IV Ondansetron in patients with prolonged QT syndrome.
- http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON296402
- Exercise caution when using Ondansetron in patients with risk factors for QT interval prolongation or cardiac arrhythmias. These include electrolyte abnormalities, use of other medicines that prolong QT interval (including cytotoxic drugs), or drugs that may cause electrolyte imbalance; congestive heart failure; bradyarrhythmias; or use of medicines that lower the heart rate.

- Counselling re. use of ondansetron:

  Discuss very small increased risk of orofacial clefts associated with ondansetron. Absolute risk increases from a background risk of 11 cases per 10,000 births to 14 cases per 10,000 (infographic from Irish Medicines in Pregnancy Service)

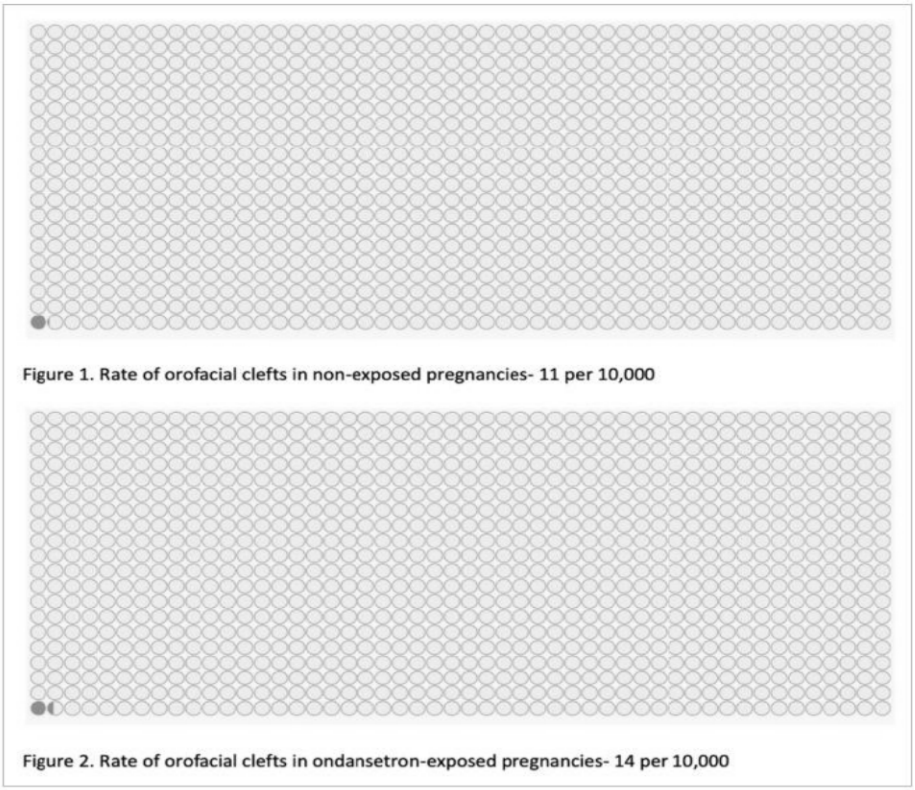


Figure 1. Rate of orofacial clefts in non-exposed pregnancies- 11 per 10,000

Figure 2. Rate of orofacial clefts in ondansetron-exposed pregnancies- 14 per 10,000

4.8.2 **Corticosteroids**

The use of steroids for management of HG is a **consultant only decision**

The use of steroids should be considered third line, and reserved for cases where standard therapies have failed. When initiated they should be prescribed in addition to previously started effective antiemetics. Women taking corticosteroids should have their blood pressure monitored and a screen for diabetes mellitus.

Suggested regime:

Hydrocortisone 100mg IV BD, once clinical improvement occurs convert to prednisolone 40–50 mg daily PO, with the dose gradually tapered (by 5-10 mg per week) until the lowest maintenance dose that controls the symptoms is reached.

4.8.3 **Proton pump inhibitors**

Consideration should be given to PPI prescription to manage reflux or oesophagitis. The treatment of gastro-oesophageal reflux, along with anti-emetic therapy, has been associated with reduced PUQE- 24 scores and improved quality of life score.

Suggested regime:

Omeprazole: 20mg PO once daily

4.8.4 **Vitamin supplementation**

All women with hyperemesis gravidarum should receive supplementation with thiamine (vitamin B1) in order to prevent Wernicke's encephalopathy.

Suggested Regime:

Vitamin B and C strong intravenous injection: one pair of ampoules in 50mls 0.9% saline infused IV over 30-60 minutes **once weekly** if oral thiamine not tolerated

Thiamine: 100mg PO TDS until normal diet resumed

4.8.5 **VTE prophylaxis**

Hyperemesis is associated with an increased risk of venous thromboembolism due to dehydration and immobility. Women being admitted to hospital should be offered thromboprophylaxis with low-molecular-weight heparin unless there are specific contraindications such as active bleeding. Those being managed in the community should have a risk assessment carried out as per antenatal proforma. Thromboprophylaxis can be discontinued on discharge, provided there are no other indications for continuation.

4.8.6 **Fluid and electrolyte replacement**

0.9% sodium chloride with additional potassium chloride is the most appropriate method of intravenous rehydration. Prescription should be guided by **daily monitoring** of serum electrolytes. The aim is to supplement oral intake, correct biochemical abnormalities and reduce the signs and symptoms of dehydration. Fluids containing dextrose **should be avoided** as they may precipitate Wernicke's encephalopathy.

Suggested regime:

2000mls 0.9% NaCl with 20mmol KCl at rate of 500ml/h

Serum biochemistry should be checked before prescribing any subsequent bags. If further IV rehydration required it should be prescribed as:

1000mls of 0.9% NaCl with 20mmol KCl over 8 hours.

Fluids should be required according to U+E results as more or less potassium supplementation may be required.

4.8.7 Nutrition

Encourage women to:

- Eat and drink little and often
- Eat meals that are high in carbohydrate and low in fat e.g., potato, rice, pasta, plain biscuits, or crackers
- Avoid any foods or smells that trigger symptoms
- Only drink clear fluids e.g., water or electrolyte (sports) drinks

Ensure that women with NVP and HG are taking multivitamins, folic acid and vitamin D supplementation, where tolerated. Iron-containing medications may be poorly tolerated and may be stopped until symptoms of NVP have improved.

4.9 Discharge advice

Women with NVP can be discharged when they are rehydrated and able to tolerate a light diet, oral fluids and antiemetic medications.

On discharge:

- At least 4 weeks of antiemetic should be prescribed, along with oral thiamine 100mg TDS until normal diet is resumed.
- Patient should be supplied with RCOG Patient information leaflet-'Pregnancy sickness'- Appendix 1, contains information on when to reduce antiemetics
- Women should be advised to contact their GP should symptoms worsen.
- Appropriate follow up should be arranged e.g. booking or antenatal appointment.
- Further support resources provided- Pregnancy Sickness Support Website,

4.10 Accessibility

The Maternity Service recognises the need to consider accessibility to this service; this will require provision of reasonable adjustments to ensure equity of opportunity. The service is committed to ensure consent is informed, by providing communication in alternative formats e.g. to undertake translation of written material such a leaflets on request and the use of the NI HSC Regional Interpreting Service, Big Word telephone interpreting service and telephone texting.

All staff will have the opportunity to undertake Mandatory Equality training and Disability awareness training.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

5.1.1 All obstetricians and midwives

5.1.2 Notify [redacted] if there are significant barriers and timescales are not being met.

5.2 Resources

5.2.1 The guideline should be disseminated by email to all obstetricians and midwives in the Belfast Trust, and uploaded onto the Loop. A triage tool for PUQE scoring system to be created on encompass for use at telephone and midwifery triage.

5.3 Exceptions

5.3.1 None

6.0 MONITORING

6.1 This guideline contains the current evidence based data on the management of women with Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum, if the need arises the guideline will be updated to align with the most up to date evidence based information available.

6.2 Following clinical audit an addendum of the guideline may be necessary.
Any change to a clinical guideline requires that it must be ratified by the Guideline group locally and minuted at Directorate.
Review dates for guidelines will be set at a period of three years; however this set period can be overridden in the light of new clinical evidence.
All unused/previous guidelines will be logged and archived electronically, and in paper format within the trust

7.0 EVIDENCE BASE/REFERENCES

RCOG Green-top guideline No. 69: The Management of Nausea and vomiting in pregnancy and Hyperemesis Gravidarum February 2024

8.0 CONSULTATION PROCESS

The following groups were consulted during the development and update of this policy:

- Midwives
- Consultant Obstetricians

This guideline was also presented at the following meeting:

- RJMS Patient Safety, Audit & Mortality Meeting

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

10.0 APPENDICES

Appendix 1: RCOG Patient Information Leaflet

11.0 EQUALITY SCREENING

Under Section 75 of the Northern Ireland Act 1998 the Trust has a legal responsibility to undertake an equality screening of all policies. To fulfil this duty an equality screening template must be completed by the policy author.

To complete an equality screening use this template: (LINK)

For support with completion of the template go to: Equality Screening Toolkit

For any queries and/or to obtain approval contact the Planning and Equality Team contact: equalityscreenings@belfasttrust.hscni.net or 028 95 048734

Equality Screenings are public documents and previously completed documents can be viewed at Equality and Human Rights Screening | Belfast Health and Social Care Trust (hscni.net)

12.0 STATUTORY RURAL IMPACT ASSESSMENT DUTIES

The Trust has a legal responsibility to have **'due regard'** to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. For more information go to Rural Needs Duties

To satisfy this '**due regard duty**' Trust staff must consider the impact of any policy, proposal or decision on the social and economic needs of people who live in a rural community. For Belfast Trust, this is particularly so when the policy/proposal/decision impacts regional services.

Please tick the box to indicate that you have paid 'due regard' to the social and economic needs of the rural community when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services and that a rural impact assessment is not required. ☒

OR

Please complete a Rural Needs Impact Assessment Template if there is an impact on the social and economic needs of people who live in a rural community.

Please go to the: Rural Impact Assessments Toolkit for HSC NI to find out how to undertake a rural impact assessment.

Contact [redacted]@belfasttrust.hscni.net for further advice

13.0 STATUTORY EQUALITY DUTIES – MAKING REASONABLE ADJUSTMENTS AND INFORMATION ACCESSIBLE

Under the Disability Discrimination Act 1995 (as amended) the Trust has a statutory duty to **make reasonable adjustments** in respect of disabled patients/service users/carers/visitors. This includes making all communication (in person, by phone, via email) *and* any information provided (in writing, verbally) accessible using alternative formats. The aim of the reasonable adjustment duty is to reduce or remove any barrier a person with a disability faces when accessing or using goods, facilities and services. This is a non-delegable duty.

Accessible/ Alternative formats can include, for example, information translated into Easy Read format or into Audio format - when a patient/service user/carer/visitor has a learning disability or is visually impaired.

In addition, if a patient/service user/carer/visitor does not speak English as their first language or has poor English, the Trust has a statutory duty **to provide an interpreter** and to **translate written information**. This facilitates informed consent, better understanding and greater independence.

For information, advice and guidance about these duties contact the Trust Planning and Equality Team equality.team@belfasttrust.hscni.net

Please tick the box to indicate that you have developed the policy in in accordance with the Trust's legal equality duties and that all staff will make reasonable adjustments and information accessible as appropriate. ☒

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

[redacted]

Policy Author **Date:** 05/06/2025

[redacted]

Director **Date: __06 June 2025_____**

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Appendix 1

Royal College of Obstetricians & Gynaecologists

Information for you

Published February 2024

Pregnancy sickness (nausea and vomiting of pregnancy and hyperemesis gravidarum)

About this information

This information is for you if you want to know more about nausea and vomiting of pregnancy or about hyperemesis gravidarum, which is the most severe form of the condition. It may also be helpful if you are a relative or friend of someone who is in this situation.

The information here aims to help you better understand your health and your options for treatment and care. Your healthcare team is there to support you in making decisions that are right for you. They can help by discussing your situation with you and answering your questions.

Key points

- Nausea and vomiting of pregnancy is a common condition that settles by 20 weeks in 9 out of 10 pregnant women.
- Hyperemesis gravidarum is a severe form of this condition and can affect up to 3 in 100 pregnant women.
- Nausea and vomiting and hyperemesis gravidarum can affect your mood, your work, your home and your social life.
- While most women can be treated at home or as outpatients in hospitals, 1 in 5 affected women may need admission to hospital for treatment.
- Several different anti-sickness medicines are available that may help your symptoms. While some of these medicines may not be licensed for use in pregnancy, they are considered safe for you and your baby.



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Within this information we may use the terms 'woman' and 'women'. However, we know that it is not only people who identify as women who may want to access this information. Your care should be appropriate, inclusive and sensitive to your needs whatever your gender identity.

A glossary of medical terms is available on the RCOG website at: https://www.rcog.org.uk/for-the-public/a-z-of-medical-terms/.

What is nausea and vomiting of pregnancy?

Nausea and vomiting are symptoms of pregnancy that affect most women. It starts early in pregnancy, usually between the 4th and 7th week. It settles by 20 weeks in 9 out of 10 women, although in some women it may last longer. It is often called 'morning sickness' but it can occur at any time of the day or night.

The cause is thought to be hormones which are produced in pregnancy in all women. Research suggests that some women get pregnancy sickness worse than others due to genetic differences, which causes them to have higher levels of a hormone called GDF-15. GDF-15 is a hormone produced by the placenta that causes a loss of appetite and nausea.

You are more likely to have pregnancy sickness if:

- you have had it before
- you are having more than one baby (twins or triplets)

It is important that other causes of vomiting are considered and looked into, particularly if:

- you have pain in your tummy or
- you have other symptoms for example pain passing urine
- you have had other medical conditions for example a stomach ulcer or gall stones, or
- your vomiting only starts after 16 weeks of pregnancy.

What is hyperemesis gravidarum?

If the nausea and vomiting becomes so severe that it stops you from doing your daily activities and you are unable to eat and drink normally, it is known as hyperemesis gravidarum. This may affect up to 3 in 100 pregnant women.

It can cause you to become dehydrated. Signs of dehydration include feeling 'dry' or very thirsty, becoming drowsy or unwell, or your urine changing from a light yellow to a dark yellow or brown colour. Women with this condition may need to be admitted to hospital.

How can it make me feel emotionally?

Nausea and vomiting of pregnancy can be a difficult problem to cope with. It can affect your mood, your work, your home situation and your social life. Support from family and friends can help. In some women, the symptoms can be so severe that they become depressed and need extra support such as counselling. If you find that you feel down then you should speak to your healthcare professional.

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Will it harm my baby?

There is no evidence that mild to moderate nausea and vomiting have a harmful effect on your baby.

Women with severe nausea and vomiting or with hyperemesis gravidarum may have a baby with a lower than expected birthweight. You may be offered scans to monitor the growth of your baby.

How can I manage my symptoms?

Most women with nausea and vomiting of pregnancy will be able to manage their symptoms themselves. You could:

- eat small amounts of foods that are high in carbohydrate and low in fat, such as potato, rice and pasta, or foods that are easier to tolerate such as plain biscuits or crackers
- avoid any foods or smells that trigger symptoms.

If your symptoms do not settle or if they stop you doing your daily activities, see your GP. They can prescribe anti-sickness medication that is safe to take in pregnancy.

What if my symptoms do not settle?

Contact your GP or your midwife. They will arrange for you to be seen in the assessment unit at your hospital. This may be in the maternity department or be part of the gynaecology unit. You can also get advice by contacting NHS 111.

What happens on the assessment unit?

You will be offered a check-up that may include:

- a discussion about how long you have had your symptoms for and whether:
    - you are keeping fluids and food down
    - you have tried any medication
    - you have lost weight rapidly
    - you have any other symptoms
    - you have had this in a previous pregnancy
- a check of your general health including your temperature, pulse, breathing rate and blood pressure; you will be offered to have your weight measured and an assessment of whether you are dehydrated or undernourished.
- urine tests to look for infection
- blood tests
- an ultrasound scan if you have not had one yet in the pregnancy. This is to check how many weeks pregnant you are. It will also check for twins. If you are able to keep some fluids down but are unable to drink enough, you should be offered fluids through a drip in your arm over a short period of time. This is called rapid rehydration. You will also be offered anti-sickness medication. Many women feel much better after this and are able to go home.

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Will I need to be admitted to hospital?

Admission to hospital may be advised if you:

- are dehydrated
- have severe vomiting and are unable to keep any fluids or oral medication down
- have abnormal blood tests
- have lost a lot of weight rapidly
- have a medical condition such as a heart or kidney problem, diabetes, epilepsy or HIV and unable to take medicine orally.

What happens in hospital?

You will be given fluids through a drip in your arm. This will be continued until you are able to drink fluids without vomiting.

Each day how much you drink and how much urine you are passing will be measured. Your temperature, blood pressure, pulse, breathing rate and weight will also be recorded.

You should be offered:

- anti-sickness medication and a B vitamin called thiamine. Both of these can be given through the drip in your arm if you are unable to keep tablets down
- special stockings (graduated elastic compression stockings) to help prevent blood clots.
- medication to reduce the acid in your stomach.
- heparin injections (to thin your blood). Pregnant women are at increased risk of developing blood clots in their legs, called deep vein thrombosis (DVT) or in their lungs (called pulmonary embolism). Being dehydrated and not being mobile increases this risk further. Heparin injections reduce this risk. You will be advised to continue these until you leave hospital and sometimes for longer. For further information, see the RCOG patient information ***Reducing the risk of venous thrombosis in pregnancy and after birth*** (https://www.rcog.org.uk/for-the-public/browse-our-patient-information/reducing-the-risk-of-venous-thrombosis-in-pregnancy-and-after-birth-patient-information-leaflet/)

If you are taking iron medication, this can be stopped temporarily because it can make sickness worse.

When you are feeling better, you can start to drink and eat small amounts and slowly build up to a normal diet.

What anti-sickness medication will I be offered?

There are several different types of anti-sickness medicines that you may be offered.

- An oral medication that is a slow-release combination of doxylamine and pyridoxine (vitamin B_6) called Xonvea™ is the only licensed treatment of nausea and vomiting in pregnancy in the UK.
- Cyclizine can be taken by mouth or by an injection. Prochlorperazine, chlorpromazine and promethazine can also be tried if cyclizine has not worked.

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- All the medications above are considered to be safe in pregnancy. Occasionally, you may require a combination of two or more anti-sickness medications.
- Metoclopramide, domperidone and ondansetron are other medications that may be prescribed for nausea and vomiting and can be taken by mouth or by an injection. These are also considered safe to use in pregnancy. They are usually used if the previous medications have not worked. This is due to a small risk of side effects. Your health care professional can discuss this with you.
- Corticosteroids may also be considered if:
    - you are still suffering from hyperemesis gravidarum despite fluids being given through a drip and regular anti-sickness medication has not helped
    - you have lost a lot of weight.

Corticosteroids are successful in helping nausea and vomiting in many women where all other measures have not helped. Most women will be able to stop corticosteroids by 18–20 weeks but a few women will need to continue them at a low dose for the rest of the pregnancy. If you are taking corticosteroids, you will be offered a test for gestational diabetes.

If hyperemesis gravidarum is not treated, it may cause more harm to the baby than any possible effects of a medicine recommended by your doctor.

What happens after I'm discharged from hospital?

You will be offered anti-sickness tablets to take home. If you feel better, you can cut down the number of tablets. If your vomiting gets worse, you may put eating on hold but try to keep sipping fluids and taking the anti-sickness tablets until you start to feel better. Ask your GP for a repeat prescription before your tablets run out.

Your symptoms may return and you may become dehydrated. If this happens, contact your midwife, GP or maternity unit to be assessed again.

If you have ongoing severe nausea and vomiting after 20 weeks, contact your midwife or GP. They may offer you ultrasound scans to monitor the growth of your baby in later pregnancy.

Although this can be a difficult situation for you and may affect you throughout your pregnancy, the symptoms usually resolve or improve after your baby is born. If you have any ongoing concerns, contact your midwife or GP for advice and support.

Emotional support

Having pregnancy sickness can be stressful and can affect your mental wellbeing. If you are feeling anxious, depressed or worried in any way, please speak to your healthcare team who can answer your questions and help you get support. The support may come from healthcare professionals, voluntary organisations or other services. Further information and resources are available on the NHS website:

https://www.nhs.uk/mental-health/

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Further information

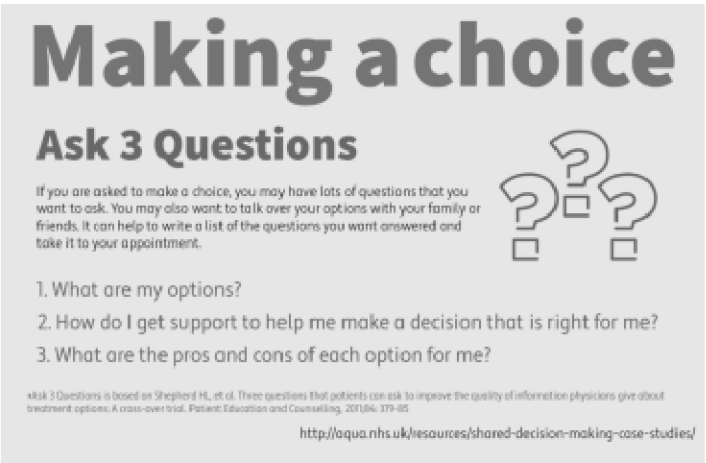
NHS information on Nausea and morning sickness: www.nhs.uk/conditions/pregnancy-and-baby/pages/morning-sickness-nausea.aspx

Pregnancy Sickness Support: www.pregnancysicknesssupport.org.uk

BUMPS: Best use of medicine in pregnancy: https://www.medicinesinpregnancy.org/

Mental Health in pregnancy: https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-in-pregnancy?searchTerms=pregnancy%20sickness

Making a choice



Making a choice

Ask 3 Questions

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

1. What are my options?
2. How do I get support to help me make a decision that is right for me?
3. What are the pros and cons of each option for me?

*Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;86: 379-85

http://aqua.nhs.uk/resources/shared-decision-making-case-studies/

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Clinical Guideline The Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum which you can find online at: https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/the-management-of-nausea-and-vomiting-of-pregnancy-and-hyperemesis-gravidarum-green-top-guideline-no-69/.