Frimley Health
NHS Foundation Trust

Nausea and Vomiting of Pregnancy (NVP) and Hyperemesis Gravidarum (HG), Management of

Key Points

- To inform midwives and obstetricians about management of pregnant women with nausea and vomiting and Hyperemesis Gravidarum both in the outpatient and inpatient settings.
- Many women with NVP and HG find it very hard and distressing to be away from their families and daily activities of daily life. Outpatient management of hyperemesis is preferred, allowing her to remain at home where possible, and has economic benefits for the health service, reducing the number of admissions.
- Women with mild vomiting and nausea in pregnancy should be treated in community by their GP with antiemetics.

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Abbreviations

EPU	Early Pregnancy Unit
GI	Gastro-intestinal
HG	Hyperemesis Gravidarum
MEOWS	Modified Early Obstetric Warning System
NVP	Nausea and vomiting of pregnancy
PUQE	Pregnancy-Unique Quantification of Emesis
UGCC	Urgent Gynaecology care centre

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Introduction

Nausea and vomiting of pregnancy (NVP) affect up to 80% of pregnant women and should be diagnosed only when the onset is in the first trimester of pregnancy, and other causes of nausea and vomiting (e.g., urinary tract infection) have been excluded.

Hyperemesis Gravidarum (HG) is a severe and intractable form of nausea and vomiting of pregnancy, which affects 0.3-3.6% of pregnant women, where there is triad of >5% pre-pregnancy weight loss, dehydration and electrolyte imbalances. Nutritional deficiencies may result, and very severe cases can develop renal and/or hepatic dysfunction. Reported recurrence in subsequent pregnancies varies from 15-80%. It typically starts between the fourth and seventh weeks of pregnancy with peak incidence at 9 weeks and symptoms usually resolve by 20 weeks in 90% of patients. If the initial onset is after 10+6 weeks of pregnancy, other causes need to be considered.

Table 1: Differential Diagnosis

Genitourinary	Urinary tract infection / pyelonephritis
Gastrointestinal	Gastritis Reflux oesophagitis Gastroenteritis Peptic ulcer Bowel obstruction Hepatitis Cholecystitis Pancreatitis
Endocrine	Diabetes Hyperthyroidism Addison's Disease Hypercalcaemia
Drug-induced	Antibiotics Iron supplementation
Neuro-vestibular disease	Labyrinthitis Benign Positional Vertigo
Psychiatric illness	Depression

Day-case rehydration in UGCC or A&E is preferred as it has advantages for the woman, allowing her to remain at home, and has economic benefits for the health service, reducing the number of admissions. Women with mild nausea and vomiting should be managed in the community by their GP with antiemetic.

Risk factors

- Non-Caucasian ethnicity.
- History of hyperemesis in previous pregnancy.
- Primiparous.
- Non-smokers.
- Multiple gestation.
- Gestational trophoblastic disease.
- Pre-existing conditions; diabetes, hyperthyroid disorder, depression or psychiatric illness, asthma, and GI disorders.

Postulated mechanisms

- Human chorionic gonadotropin (HCG) stimulating secretory processes in the upper GI tract, and/or stimulation of the thyroid stimulating hormone receptor. Conditions with higher HCG levels, such as trophoblastic disease and multiple pregnancy, have been associated with increased severity of NVP
- Oestrogen levels have also been positively associated with nausea and vomiting in pregnancy, perhaps through delayed GI motility and gastric emptying.
- Physiological stimulation of the thyroid gland in early pregnancy causes a transient thyrotoxicosis that may lead to hyperemesis.

Complications

In cases where hyperemesis is severe and prolonged, there is considerable physical and psychological morbidity for the woman. Multiple hospital admissions disrupt family life and increase costs for the NHS. It is the most common indication for hospitalization in early pregnancy, and the second most common indication for hospitalization in pregnancy.

HG is associated with both maternal and perinatal morbidity.

Maternal complications include

- Malnutrition and vitamin deficiencies.
- Weight loss and dehydration causing ketonuria and ketonemia.
- Electrolyte imbalance such as hyponatremia, hypokalemia, or hypochloremia (central pontine myelinolysis can result from too rapid correction of low sodium).
- Venous thromboembolism.
- Acute kidney injury.
- Abnormal liver function tests.
- Psychological disturbances; depression, anxiety, emotional distress, post-traumatic stress disorder, and reduced quality of life.
- Wernicke’s encephalopathy due to vitamin B1 (thiamine) deficiency.
- Esophageal tears (Mallory-Weiss tears) and rarely esophageal rupture.
- Spontaneous pneumothorax or pneumomediastinum.
- Splenic avulsion.
- Retinal hemorrhage.

Fetal complications include

- Preterm birth.
- Low birthweight
- Small for gestational age

Initial Management of NVP and HG

Women with mild NVP should be managed in the community with antiemetics.
Day care management (UGCC/A&E) should be used for suitable patients when community/primary care measures have failed and where the Pregnancy-Unique Quantification of Emesis (PUQE) score is less than 13.

The **PUQE score** [5] can be used as a telephone triage sheet for patients who self-refer with NVP to determine whether it is mild, moderate or severe (Appendix 1). Total score is sum of replies to each of the three questions.

PUQE-24 score: Mild ≤ 6; Moderate = 7–12; Severe = 13–15.

Score 3-12: Community management, give dietary and lifestyle advice

Score >13 and no complications – day case management in hospital

Score > 13 with complications and unsuccessful day care – inpatient admission required.

Criteria for health professionals referring: Vomiting > 24hrs and unable to maintain adequate oral hydration at home for 12hrs or more and/or moderate ketosis on urinalysis (2+ to 4+).

FPH Site: Women of all gestations with HG to be accepted in UGCC on a case-by-case basis within working hours. Only 1 woman at a time can be accepted on UGCC otherwise should attend A&E. If requires admission <16/40 admit to F15 if possible.

WPH Site: Women <16/40 will be accepted in UGCC, If more than >16/40 MAC.

Initial assessment and investigation by A&E nurse or Nurse and SHO on UGCC
Use hospital site specific Hyperemesis Proforma for day-case care:
(Outpatient Management of Hyperemesis at **Frimley Park Hospital** - **Appendix 2** &
Algorithm for Assessment of Hyperemesis Gravidarum at **Wexham Park - Appendix 3)**.

History

- Previous history of NVG/HG
- Associated symptoms to exclude other causes such as urinary symptoms, abdominal pain, diarrhoea, vertigo or drug history (Refer to Table 1 on page 3).
- Determine severity using PUQE score: nausea, vomiting, hypersalivation, weight loss, inability to tolerate foods and fluid and effect on quality of life.

Physical Examination

- Full set of observations – Respiratory rate, Pulse, Blood Pressure, Temperature and Oxygen Saturations (record on MEOWS Chart).
- Abdominal examination
- Weight
- Signs of dehydration – decreased skin turgor; postural changes in blood pressure and pulse
- Sign of muscle wasting
- Additional examinations as guided by history.

Investigations

- Urine dipstick: test for ketonuria 2+ or more and to rule out UTI. **NB** *if glycosuria is present as well as ketones consider diabetes* (For day-case management do not re-dip before sending home)
- MSU for culture and sensitivity if protein, leucocytes or nitrites on dipstick
- FBC, U&Es, LFT's & VBG (exclude metabolic disturbances)
- In refractory cases or history of previous admission, check TFT's, calcium, phosphate, amylase.
- Blood glucose monitoring to exclude diabetic ketoacidosis if diabetic.
- Ultrasound scan on EPU – IF NO BOOKING SCAN YET to confirm viable intrauterine pregnancy and exclude multiple and gestational trophoblastic disease. If necessary, this can be arranged after discharge if she does not require inpatient management for the next available appointment.

Liver function

There may be mild derangement in 40% of women, including raised transaminases, mildly raised bilirubin in the absence of jaundice and mildly raised amylase, which all improve as the HG resolves.

Thyroid function

Transient hyperthyroidism is seen in about 60% of patients with hyperemesis gravidarum (based on a structural similarity between thyroid-stimulating hormone [TSH] and hCG). Consult Endocrinologist if thyroid function tests are significantly abnormal.

Treatment

Avoid glucose containing fluids – carbohydrate rich IV fluids may precipitate Wernicke's encephalopathy.

1. Fluid and Electrolyte Replacement:

- 1st bag – 1L Sodium chloride 0.9% or Plasma-Lyte 148 over 1 hour
- 2nd bag- 1L Sodium chloride 0.9% or Plasma-Lyte 148 over 2-3 hours

If K+ < 3.4 mmol/l – needs KCL replacement e.g. 20mmol in the second litre. Additional fluid and electrolyte requirements should be adapted based on urinalysis & U&E's. If abnormal U&E's or requiring>3L of fluids, they need admission and recheck U&Es (6hrs after initial bloods).

2. Anti-Emetic Therapy

Withhold non-essential medications associated with nausea & vomiting, e.g., oral iron. Consider alternative routes for essential medications, e.g., antiepileptics. The first dose should be by intravenous or intramuscular injection and then if tolerated oral therapy can be continued.

Table 2: Anti-emetic prescription. Use in the following order, unless previously ineffective with good compliance:

	Antiemetic	Dose	Prescribing info
First-line	**Cyclizine**	50mg 8-hourly PO/IM/IV	*Preferred first-line option due to cost-effectiveness*
	Doxylamine succinate and pyridoxine hydrochloride 10 mg/10 mg gastro-resistant tablets (Xonvea®) [licensed]	1 tablet PO at night. If NVP not controlled after day 2, increase in steps of 1 tablet i.e. 1 tablet OM and 2 tablets ON. If necessary, can be increased to 1 tablet OM, 1 tablet in the afternoon and 2 tablets ON	*When this is no longer required, dose should be tapered down gradually to prevent a sudden return of NVP.*
	Promethazine	12.5-25mg 4-8 hourly PO/IM/IV/PR	*Switch to oral after 24 hours*
	Prochlorperazine	5-10mg 6-8 hourly PO; 12.5mg 8-hourly IM/IV; 3-6mg 12-hourly buccal	
	Chlorpromazine	10-25mg every 4-6 hours PO/IV/IM	
Second-line	**Ondansetron**	4-8mg 6-8 hourly PO; 8mg over 15 minutes 12 hourly IV; 16mg 24-hourly PR. Should not be prescribed for longer than 5 days.	*Recent studies found small risk of 3 cleft palates in every 10,000 women that used Ondansetron in the first trimester. Should be avoided in first trimester if possible; otherwise, full informed consent with documentation should be gained.*
	Metoclopramide	10mg PO/IM/IV 8 hourly (Reduce dose to 5mg in patients <60kg (0.5 mg/kg body weight in 24 hours). Maximum 5 days' duration.	*There may be extra-pyramidal side effects and oculogyric crises with metoclopramide. Treatment involves stopping the medication, procyclidine 5mg stat IM or IV (repeat after 20minutes if necessary).*
Third-line	If all other medication is ineffective consider corticosteroids with consultant decision.		

Review the need for ongoing treatment and advise on gradually reducing and stopping medication when symptoms improve, depending on clinical judgement.

Non -Pharmacological interventions:

-Ginger may be used as an adjunct to anti-emetics or by women wishing to avoid antiemetics in mild to moderate NVP.

- Acupressure and Acupuncture: Women may be reassured that it is safe in pregnancy such as over the P6 point (2.5 finger breadths up from the wrist crease on the ventral aspect of the wrist) using a wrist band or finger pressure.

- Diazepam is not recommended for use in treating hyperemesis.

Inpatient management criteria (if at least one of the following present):

- Continued nausea and vomiting and unable to keep down oral fluids and antiemetics
- Weight loss >5% of their pre-pregnancy weight and consider dietetic referral
- Confirmed or suspected comorbidity (such as urinary tract infection and inability to tolerate oral antibiotics, abdominal pain and diabetes)
- Significantly abnormal U&Es at discretion of medical staff
- Haematemesis

Inpatient treatment
Aims of inpatient treatment:

- To correct electrolyte imbalance and dehydration;
- To provide symptomatic relief;
- Prophylaxis against recognized complications.

Intravenous fluid and electrolyte replacement
Fluids should be administered if there are any of the following:

- ≥2+ ketones in the urine;
- Clinical signs of dehydration;
- History suggestive of inadequate oral intake.

If the serum potassium level is <3.4 mmol/L potassium supplements should be given. The rate of the fluid administration should be individualised to each patient.
Consider dietary sources of potassium such as orange juice or bananas (if tolerated) or tablets of Sando-k.

Insulin dependent diabetic patients will require VRIII (variable rate intravenous insulin infusion). Please consult with the Diabetes Team about the management of these patients.

Anti-emetics
Refer to Anti-emetic therapy in Table 2.

Corticosteroids
If no other methods are working and HG severe and clinically unwell consider corticosteroids (discuss with consultant):
Hydrocortisone 100mg 12-hourly IV until clinical improvement and convert to prednisolone 40–50mg daily PO, with the dose gradually tapered until the lowest maintenance dose that controls the symptoms is reached. Suggested PO prednisolone regime: 40mg OD for 1 day; 20mg OD for 3 days; 10mg OD for 3 days; 5mg OD for 7 days. This regimen can be repeated up to three times in 6 weeks.

Antacids
If the patient has any symptoms of heartburn or gastritis omeprazole can be used. Addition of antacids can also be considered.

Vitamin supplements
- Thiamine (vitamin B1) 50mg PO TDS should be given to all women admitted with prolonged vomiting (can be continued till delivery) OR if oral supplement not tolerated Pabrinex IV ampoules no.1 and no. 2 diluted in 100mL of sodium chloride 0.9 infused over 30 to 60 minutes, once a week.
  Note: there can be serious adverse reactions to Pabrinex if glucose is used or after parenteral administration, including anaphylaxis; therefore, the patient needs to be monitored. In these patients perform observations before, 30mins and end of infusion.
- Folic acid 5mg OD PO in first trimester
- Withhold iron supplements during admission as these might exacerbate symptoms.

Thromboprophylaxis
- Anti-embolism Stockings
- Thromboprophylaxis with low-molecular-weight heparin should be prescribed as per the maternity VTE guideline unless there are specific contraindications such as active bleeding. Thromboprophylaxis can be discontinued upon discharge.

Inpatient monitoring
- Serum electrolytes and renal function should be checked daily whilst patients are receiving intravenous fluids to ensure electrolyte imbalances are corrected;
- Strict fluid balance chart. For review by doctor if urine output<0.5ml/kg/hr.
- Daily urine dipstick.
- Weekly weight.
- Assess the patient's intake, including diet and if there seems to be malnutrition, a referral to the dietitian should be made.

In women with severe NVP or HG, input may be required from other professionals, such as midwives, nurses, dieticians, pharmacists, endocrinologists, gastroenterologists, and a mental health team, including a psychiatrist.

Discharge

Women with NVP and HG should have an individualised management plan in place when they are discharged from hospital.

Before discharge the patient should be able to:

- Tolerate oral fluids
- Have no clinical signs of dehydration (pulse<100bpm and urine output ≥ 0.5ml/kg/hr).
- <2+ Ketones in diabetic patients. In all other patient no need to recheck.

- Write Thiamine (vitamin B1) 100mg PO OD, folic acid 5mg OD (both continued throughout first trimester) and anti-emetics.
- Give dietary information leaflet; dietary modifications include recommendations to have small and frequent meals, avoid spicy or fatty foods, and drink fluids regularly.
- For day cases, can give GP letter informing GP of their attendance and medication prescribed (Appendix 4).
- Advice about patient support groups (e.g. Pregnancy Sickness Support).

Follow-up

- Return to normal antenatal care schedule.
- If return to persistent vomiting woman advised to contact UGCC
- Women with severe NVP or HG who have continued symptoms into the late second or the third trimester should be offered serial scans to monitor fetal growth.
- Booked under consultant led care (if been admitted).

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Frimley Health NHS Foundation Trust

Appendix 1: Pregnancy-Unique Quantification of Emesis (PUQE) index
[For illustration only, to be completed in Epic.]

Patient Name: Date & Time:
Hospital Number:
NHS Number: Referral Taken by:

Total score is sum of replies for each of the three questions.

PUQE-24 scoring system					
In the last 24 hours, for how long have you felt nauseated or sick to your stomach?	Not at all (1)	1 hour or less (2)	2-3 hours (3)	4-6 hours (4)	More than 6 hours (5)
In the last 24 hours have you vomited or thrown up?	7 or more times (5)	5-6 times (4)	3-4 times (3)	1-2 times (2)	1 did not throw up (1)
In the last 24 hours how many times have you had retching or dry heaves without bringing up anything?	No time (1)	1-2 times (2)	3-4 times (3)	5-6 times (4)	7 or more times (5)

PUQE-24 score: Mild ≤ 6; Moderate = 7–12; Severe = 13–15.
Score 3-12: Community Management, give dietary and lifestyle advice.
Score >13 and no complications: day case management in DAU.
Score > 13 with complications and unsuccessful day case: Inpatient Admission required.

How many hours have you slept out of 24 hours? _____ Why? _____

On the scale of 0 to 10, how would you rate your wellbeing (0= worst possible -> 10= best you have felt)? _____

Can you tell me what causes you to feel that way? _____

Outcome/Advice given _____

Appendix 2: Outpatient Management of Hyperemesis - Frimley Park Hospital
[For illustration only, to be completed in Epic.]

Patient Name:
Hospital Number:
NHS Number:

Date: **Time Arrived:**

Current Medication:

Gestation:
Number of previous attendances:

Doctors History and examination:

Further comments:

Admit

- ☐ Prescribe more fluid
- ☐ Anti-emetics prescribed
- ☐ Patient Centre
- ☐ Wrist band
- ☐ VIP chart
- ☐ VTE

Time Admitted:

Cannula insertion (Hand washed, Gloves, Aseptic Insertion, Cannula secured with Dressing)

Date & Time Inserted: _____
Site: _____Gauge:_____
Inserted By: _____
Time Removed: _____
Removed By: _____

Blood Results (start a blood sheet if not back by discharge):

Hb:	Na:
WCC:	K:
Platelets:	Urea:
Creat:	Bili:
AST:	Albumin:
ALT:	Other:

Book USS if <12/40 Date/Time

- Document Observation on MEOWs chart
- Bloods Taken (FBC and U&E's)
- In persistent or history of previous admission, check – TFT's, LFT's, Calcium, Amylase & ABG
- Urine Dip:
- Send MSU
- Commence accurate fluid balance
- Booking weight: …….. Current weight: ……..
- % weight loss: ……..

Prescribe IV Fluid (commence fluid balance)

- 1st bag: 1L sodium chloride 0.9%/plasmalyte over 1 hour
- 2nd bag: 1L sodium chloride 0.9%/Plasmalyte over 2-3 hours (consider potassium if <3.4mmol/l)

Prescribe regular and PRN Antiemetics

- IV/IM/PO cyclizine 50mg
- IM prochlorperazine 12.5mg
- Metoclopramide10mg PO/IM/IV 8 hourly (Reduce dose to 5mg in patients <60kg)
- IV/IM/PO ondansetron 4-8mg (informed consent)
- Thiamine (vitamin B1) 100mg PO OD & folic acid 5mg OD (until 12/40)
- **Write TTO**

Discharge home: (no need to re dip urine)

- ☐ Tolerating oral Fluids
- ☐ TTO
- ☐ Dietary Advice
- ☐ Information Leaflet
- ☐ GP Letter
- ☐ Contact telephone numbers

Time Discharged home:

Appendix 3 - Algorithm for Assessment of Hyperemesis Gravidarum - Wexham Park
[For illustration only, to be completed in Epic.]

(Please print this algorithm and add to patient's notes)

Surname: First Name: Hospital Number: DOB:

(Sticker if available)

History

Parity No. of admissions
Gestation LMP
Nausea and vomiting? ☐
Objective weight loss? ☐
Other symptoms (exclude other causes e.g. UTI, drugs, thyroid disease, DKA, gastroenteritis):

Significant PMHx

Allergies

Drug History

Examination

Weight:

P	BP	T	RR	Sats

Hydration assessment:

CRT	JVP	Mucous membranes	Skin turgor

General examination:

Modified 24-hour PUQE Score

1. On average in a day, for how long have you felt nauseated or sick to your stomach?

Symptom	Not at all	≤1 hour	2-3 hours	4-6 hours	> 6 hours
Score	(1)	(2)	(3)	(4)	(5)

2. On average in a day, have you vomited or thrown up?

Symptom	7+ times	5-6 times	3-4 times	1-2 times	0 times
Score	(5)	(4)	(3)	(2)	(1)

3. On average in a day, how many times have you had retching or dry heaves without bringing anything up?

Symptom	Not at all	1 -2	3-4	5-6	7 or more
Score	(1)	(2)	(3)	(4)	(5)

Total Score questions 1-3:

Mild ≤ 6 – can be managed as outpatient
Moderate 7-12 – inpatient management or If goes home – review the following day
Severe ≥ 13 – inpatient management

On a scale of 0 to 10, how would you rate your wellbeing (0 = worst possible, 10 = best you felt before pregnancy):

Daily assessment

Date						
PUQE Score						
Wellbeing Score						
Weight						
Urine Ket						
Urine Leu						
Hb						
Hct						
WBC						
CRP						
Na						
K						
Urea						
Creatinine						
Bilirubin						
ALT						
Signature						

Appendix 4 (a) – Template for Letter to Patient's GP (Frimley Park)
[For illustration only, to be completed in Epic.]

Frimley Park Hospital
Urgent gynaecology care centre Nursing team
Portsmouth Road
Frimley
Camberley
Surrey
GU16 7UJ
03006136418
www.frimleyhealth.nhs.uk

Date:

Dear GP,

Patient Name:
NHS Number:
DOB:

This patient has been seen in our urgent gynaecology care centre, Frimley Park Hospital for:

The patient has all the information of the treatment and care received as an outpatient in their handheld pregnancy notes. They have been given medication to go home with, which is to be continued by the GP authorised by the doctor who has reviewed the patient.

Medication given to patient:

Please call Frimley Park Hospital Urgent gynaecology care centre (03006136418) if you have any queries.

Yours Sincerely,

Urgent Gynaecology Care Centre Nurse

Appendix 4 (b) – Template for Letter to Patient's GP (Wexham Park)
[For illustration only, to be completed in Epic.]

Wexham Park Hospital
Gynaecology Nursing team
Wexham Street
Berkshire
SL2 4HL
0300615 4429

www.frimleyhealth.nhs.uk

Date:

Dear GP,

Patient Name:
NHS Number:
DOB:

This patient has been seen in our Urgent Gynaecology Care Centre, Wexham Park Hospital for:

The patient has all the information of the treatment and care received as an outpatient in their handheld pregnancy notes. They have been given medication to go home with, which is to be continued by the GP authorised by the doctor who has reviewed the patient.

Medication given to patient:

Please call Wexham Park Urgent Gynaecology Care Centre (UGCC) (0300 6154429) if you have any queries.

Yours Sincerely,

Urgent Gynaecology Care Centre Nurse

Full version control record

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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	March 2020	Alexandra Cairns, Veluppillai Vathanan, Vidya Shirol	Final	First cross site version
2.0	March 2024	Veluppillai Vathanan, Vidya Shirol	Final	Approved at Cross Site Obstetrics Clinical Governance Meeting, 27 March 2024

Related Documents

None