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Nausea and Vomiting in Pregnancy

Introduction

Last week, a lovely woman in her 3rd pregnancy walked into my rooms at 7 weeks gestation – despite being a much wanted pregnancy, in tears was now worried that she couldn't cope and continue with the pregnancy. She hadn't been able to eat for almost a week and was vomiting throughout the day. She had suffered severe Hyperemesis Gravidarum in her first two pregnancies overseas with multiple trips every week to the Emergency Department for IV Fluids. Despite significant dehydration and as unwell as she was, she was avoiding presentation to the ED given the traumatic memories and emotions now attached to her previous pregnancies. We optimised her medications, and referring her to the NSLHD Hyperemesis service, had a nurse attend her home the same day to administer IV fluids and assist with ongoing review. Unfortunately, this is an all-too-common situation.

Nausea and vomiting is the most common medical condition in pregnancy, affecting up to 90% of women. Persistent vomiting that leads to weight loss of greater than 5% of pre-pregnancy weight occurs in 1% of pregnancies and is referred to as hyperemesis gravidarum (this is also associated with electrolyte abnormalities and dehydration). Nausea and vomiting of pregnancy usually begins at 6-7 weeks of gestation, peaks at around 9 weeks of gestation, and resolves in most cases by 12-14 weeks. In up to 20% of pregnancies, symptoms continue beyond 20 weeks.

What is the NSW Health Hyperemesis Virtual Care Service (VCS)?

The NSW Government allocated $17 million in funding for improved Hyperemesis services and each LHD was tasked with creating a relevant service. Our Northern Sydney area has an exceptional multi-disciplinary team that is able to respond to optimise medication and provide hospital-in-the-home nurses to administer IV Fluids and review. Any clinician is able to refer to this service (I have attached a QR code below that will link to the referral) – it is suggested to make an initial referral to the VCS and also consider referral to an obstetrician with an interest in this area.

Optimising Medication

Most pregnancy multivitamins contain iron, which is notorious for exacerbating nausea – withholding multivitamins containing iron (continuing only folic acid and iodine) can be helpful until any nausea and vomiting has settled down. Having a step-wise approach to medical therapy is important, however it is also critical to treat symptoms quickly to avoid unnecessary deterioration.

For mild nausea, there is some evidence for options including ginger and vitamin B6 however if vomiting and needing medical therapy, it is important to remember four components to treatment:

- Anti-emetics
- Acid suppression
- Laxatives
- IV Fluids

Anti-emetics

1st line options (both as per the TGA in Australia and the FDA in the USA) is Doxylamine (Restavit) and Vitamin B6. I often recommend starting with either 12.5-25mg Doxylamine at night and then Ondansetron during the day when needed. Further options are included below:

Anti-Emetics	Class	Dose
Doxylamine (Restavit)	Anti-histamine	12.5 - 25 mg at night, increase PRN to every 8 hrs (max dose of 50mg / 24hrs)
Ondansetron (Zofran)	5HT-3 (serotonin receptor antagonist)	4 - 8 mg, every 8 to 12 hours (max dose of 16mg / 24 hrs)
Metoclopramide (Maxalon)	Dopamine antagonist	10mg every 8 hours (max dose of 30mg / 24hrs)
Proclorperazine (Stemetil)	Dopamine antagonist	

Acid suppression

Many clinicians prescribe anti-emetics whilst not appreciating the importance of acid suppression. Progesterone acts on the gastric sphincter, worsening reflux throughout pregnancy and vomiting can also cause oesophageal damage that even once vomiting is under control, can cause epigastric discomfort for months.

Acid suppresion	Class	Dose
OTC Acid suppression (Mylanta, Gaviscon)	Antacid	PRN for mild symptoms
Omeprazole (Omepral)	Proton-pump inhibitor	20mg once or twice / day
Esomeprazole (Nexium)	Proton-pump inhibitor	20mg once or twice / day
Famotidine (Pepsid)	H2 antagonist	20mg once or twice / day

Laxatives

Pregnancy also causes prolonged gastric emptying and transit time leading to constipation. Medications such as Ondansetron can also exacerbate constipation. Constipation can cause significant abdominal discomfort. The below options all increase water content, rehydrating and bulking the stool to trigger renewed colonic activity.

Laxatives	Dose	Dose
Docustate (Coloxyl)	120mg once or twice / day	PRN for mild symptoms
Macrogol (Movicol)	1-2 sachets once or twice / day	20mg once or twice / day
Lactulose (Dulose)	15-30mls once or twice / day	20mg once or twice / day

IV Fluids

The NSLHD VCS will also be able to attend a patient's home to administer IV Fluids – hence avoiding unnecessary presentations to the Emergency Department.

IV Fluids	Volume/Rate	Practice Points
0.9% Sodium chloride or Hartmanns	1-2 litres over 1-2 hrs	Add IV Thiamine (100mg/day) if poor oral intake or administering IV glucose

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